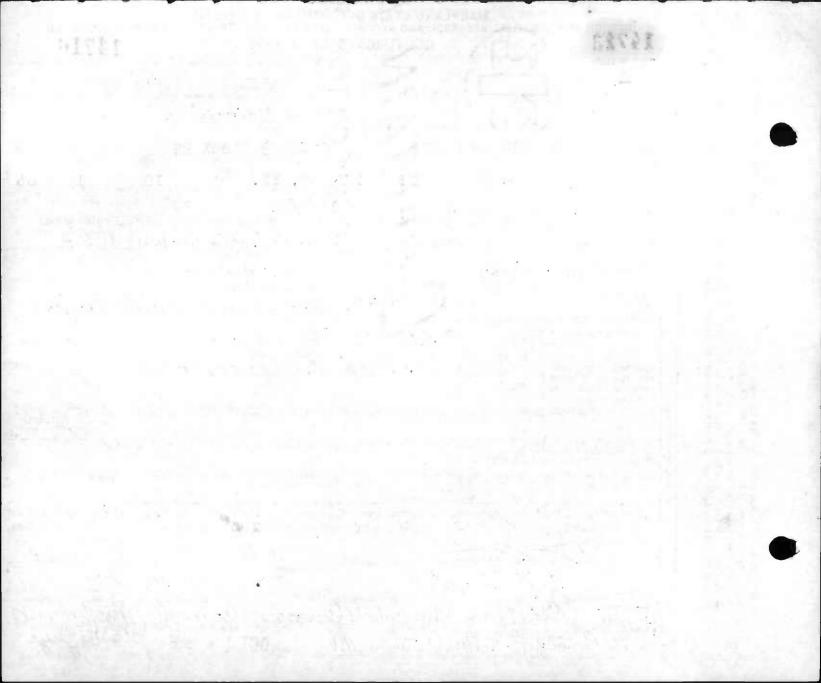
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, of formoval, and in any event, within 72 hours after death.

> VR A15 (4) 20M 1/65

|                  | MARYLAND STATE DEPARTMENT OF HEALTH  |                           |
|------------------|--|---------------------------|
| DIVISION OF      | STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMOR CERTIFICATE OF DEATH | E 1, MARYLAND             |
| 19/13            | CERTIFICATE OF DEATH   | 14716                     |
| DI SOF OF DESTIL | II O HOUSE DECIDENCE (NO   | that are Devildence but a |

| ZX-ZO OEMINIOAT  | E OI DEATH   |                            |
|--|--|----------------------------|
| 1. PLACE OF DEATH a. COUNTY  | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence b  | pefore admission)          |
| TALBOT MARYLAND  | a. STATE B. COUNTY OUTERN ANNE.  | 1                          |
| b. CITY OR TOWN (if outside corporate limits,   c. LENGTH OF STAY IN 1b  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give   | nearest town)              |
| write RURAL and give nearest town) EASTON  | RURAL CENTREVILLE  | 7.2                        |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)   |  | IS RESIDENCE<br>ON A FARM? |
| HOUSE IN THE PINES* EASTON   | ROUTE #3 BOX 95 YE   | s No 🔽                     |
| 3. NAME OF First Middle DECEASED   | Last 4. DATE Month Day   | Year                       |
| (Type or print) JOSEPH HOWARD AN   | THONY SR. DEATH 10 15  | 19 66                      |
| 5. SEX   6. COLOR OR RACE   7. MARRIED   NEVER MARRIED   | 8. DATE OF BIRTH 9. AGE (In years IF UNDER 1 YEAR IF last birthday) Months Days  | Hours   Min.               |
| MALE WHITE WIDOWED DIVORCED  | 11/8/86 /9 yrs.  |                            |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) INDUSTRY.  | 11. BIRTHPLACE (County & State, or foreign country)   12. CITIZEN OF COUNTRY?  | WHAT                       |
| RETIRED FARMER FARMING   | CENTREVILLE, W.H.Co. MREYLAND U.S.A.   | ł,                         |
| 13. FATHER'S NAME  | 14. MOTHER'S MAIDEN NAME   |                            |
| ISSAC M. ANTHONY   | SUSAN GODWIN   |                            |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17. (Yes, no. or unknown) (If yes give war or dates of service)  | INFORMANT DAUGHER Address  | , , , ,                    |
|  | 25, Charles CECIL, CENTRENCE, MARVI  | ANd                        |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]  |  | AL BETWEEN                 |
| PART I. DEATH WAS CAUSED BY: Cafe Bornel a   | Thromhosis 5   | mer                        |
| 332 X DUE TO   |  |                            |
| Conditions, If any, which \ (b) Relvance(1   | Hotoosclarosis y   | ears                       |
| gave rise to immediate cause (a), stating the DUE TO   |  |                            |
| underlying cause last. (c)   |  |                            |
|  |  | VAS AUTOPSY<br>PERFORMED?  |
| ICA1   | YES  | □ NO □                     |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUTNOT RELIGIOUS CONTRIBUTING TO DEATH BUTNOT RELIGIOUS CONTRIBUTING TO CAUSE OF DEATH CONTRIBUTING TO DEATH BUTNOT RELIGIOUS CONTRIBUTING TO CAUSE OF DEATH CONTRIBUTING TO CONTRIBUTING TO CAUSE OF DEATH CON | JRRED. (Enter nature of Injury in Part I or Part II of Item 18.)   |                            |
| G OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |                            |
| 3 20c. TIME OF INJURY Month, Day, Year   20d. INJURY OCCURRED   20e. PLA   | CE OF INJURY (Home, farm, 20f. (City or town) (County)   | (State)                    |
| ZOC. TIME OF INJURY Month, Day, Year 20d. INJURY OCCURRED 20e. PLA factor 20d. INJURY OCCURRED 20e. PLA factor 20d. INJURY OCCURRED 20e. PLA factor 20d. INJURY OCCURRED 20d. INJ | ry, street, office bldg., etc.)  |                            |
| 21. I certify that (I) (this hospital) attended the deceased from  | Meluso, 196/2 10 -15, 1966, that   | (I) (we) last              |
|  | t death occurred at 2:45 M, from the causes and on the date  |                            |
| 22a. SIGNATURE   | 22b. DATE SIGN   |                            |
| Contraction. M.C   | D. ATTENDING MED. STAFF PHYS. DIRECTOR PHYS. DIVINITION DIRECTOR DIRECTOR DIRECTOR DIRECTOR DIVINITION DIRECTOR DIVINITION DIRECTOR DIVINITION DIVINITION DIRECTOR DIVINITION DIRECTOR DIVINITION DIVINITION DIVINITION DIVINITION DIRECTOR DIVINITION DIVINI | - 6.L                      |
| 22c. PHYSICIAN'S<br>NAME (Type)  | 22d. ADDRESS   |                            |
| C. N. Laylon   | Centreville my   |                            |
| 23a. BURIAL, OREMATION, 23b. DATE THEREOF 23c. NAME OF CEMETERS  | OR CREMATORY 23d. LOCATION (City, town or county)  | (State)                    |
| BURIAL DUT, 17,1966 CHESTACHEIC  | CEMETERY CENTREVILE, VIARYAND  | 21617                      |
| FUNERAL DIRECTOR ADDRESS   | 25a. REC'D BY REGISTRAR   25b. REGISTRAR'S SIGNAT  | TURE WELL                  |
| Homes of Boilon 1, Bourn 3001, Centroutle, 11  | W. DATE OCT 18 1986 Justiles &   | 7                          |



MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

4714 CERTIFICATE OF DEATH 1. PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) b. COUNTY Talbet o. State Maryland a. COUNTY Talbat MARYLAND c. CITY OR TOWN (If autside carparote limits, write RURAL and give nearest town) b. CITY OR TOWN (If autside carporate limits, write RURAL and give nearest town) c. LENGTH OF STAY IN 1b Life Easton . Maryland e. IS RESIDENCE ON A FARM? d. STREET ADDRESS d. NAME OF HOSPITAL OR INSTITUTION (If not in haspital, give street address) RFD# 2 Memerial Hespital, Easten, Maryland YES NO [ 3 NAME OF Middle 4 DATE Year First Lost Month Day DECEASED ROY W. BAILEY Oct. 14, 19 (Type or print) DEATH IF UNDER 1 YEAR S. SEX AGE (In years IF LINDER 24 HRS 6. COLOR OR RACE DATE OF BIRTH 7. MARRIED NEVER MARRIED Jast birthday) Months Days Hours Male Mar. 2.1900 Negre DIVORCED WIDOWED 12. CITIZEN OF WHAT 10g. USUAL OCCUPATION (Give kind of work done 10b. KIND OF BUSINESS OR 11. BIRTHPLACE (County & State, or foreign country) COUNTRY? during most of working life, even if retired) INDUSTRY Not known 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME James Bailev Annie B. Green 17. INFORMANT IS. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. (Yes, no, ar unknown) (If yes give wor or dates af service) Family, RT", 2, Easten, Maryland 220-26-2513 1B. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). INTERVAL BETWEEN PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) IELONEPHRITIS DUE TO Canditians, if any, which gave (b) rise to immediate cause (a). DUE TO stating the underlying cause last. NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(0). WAS AUTOPSY PERFORMED? PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NO 20g. ACCIDENT WAS UNDERLYING 20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Part II ar Part II af item 18.) OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Home, form, (City or town) (State) 20c. TIME OF INJURY Month, Day, Year (County) Hour a.m. Not While factory, street, affice blda., etc.) at work 21. I certify that (1) (this hospital) attended the deceased fram 19 . to 19 ... that (1) (we) last M, fram causes and on the date stated above. saw the deceased alive an and that death occurred at 22g. SIGNATURE 22b. DATE SIGNED **ATTENDING** DIRECTOR PHYS. PHYS 22d. ADDRESS 22c. PHYSICIAN'S NAME (Type) NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City or Town) 23g. BURIAL CREMATION. 23b. DATE THEREOF (County) (Stote) REMOVAL (Specify) 10-18-1966 New Chapel Cometery New Chapel, Maryland ADDRESS 250. REC'D BY REGISTRAR 2Sb. REGISTRAR'S SIGNATURE 24. FUNERAL DIRECTOR Jelley, Salisbury, Maryland Wienles Jugge

law requires that the death certificate be executed within 24 hours after death ond completely filled in by the funeral remove corbon papers. Pages 1 and by the offending play physician be retained by the hospital or ottending O FUNERAL DIRECTOR: After this certificate

ond 2 death.

ion papers. Pag within 72 hours

pleose

hen

permit. 50

burial-transit

lo.

detoched

should

Dept.

State

signed

and

removal,

cremotion,

prior to hos been os the

director, should be VR A15 (4) 20 M 1/66 Section (Sec

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

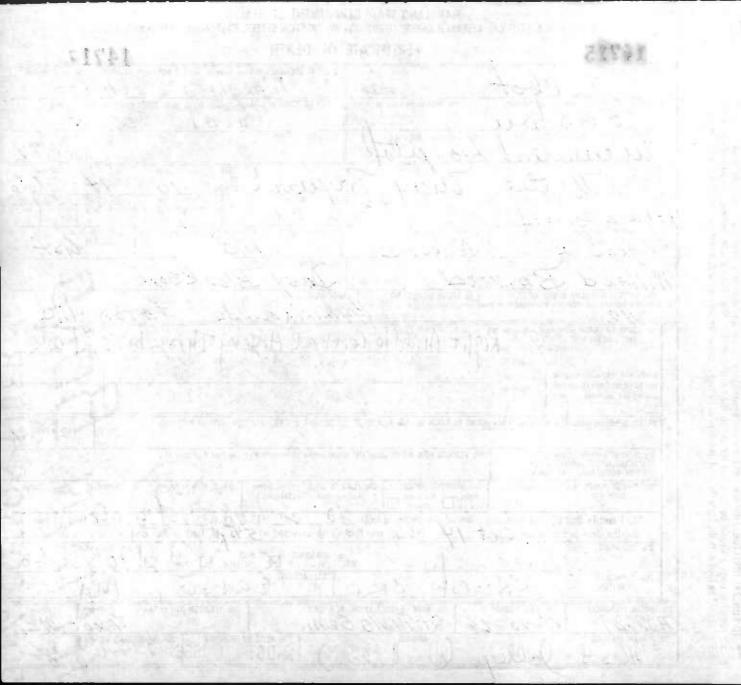
| )  |                 | 14715  | CERTIFICATE                                     | OF DEATH   | 14                                 | 717                                     |
|----|-----------------|--|---|--|------------------------------------|---|
|    | (               | PLACE DE DEATH O. COUNTY  Jachor   | MARYLAND  | 2. USUAL RESIDENCE (Where deceos<br>o. STATE MARY/A    | and b. COUNTY TA                   | 1bot                                    |
|    |                 | b. CITY DR TOWN (If outside corporate limits, write RUP and did give negrest town)                 | c. LENGTH OF STAY IN 16                         | c. CITY OR TOWN (If outside corporo                    | 1                                  | 6N20.1                                  |
| 18 |                 | d. NAME OF HOSPITAL DR INSTITUTION (IF not   | Hospital  | d. STREET ADORESS                                      |                                    | e. IS RESIDENCE<br>DN A FARM?<br>YES ND |
|    |                 | NAME OF DECEASED (Type or print)  SEX  6. COLOR OR RACE  | - May 50  | Lost 4. DATE DF DEATH DATE DE BIRTH 9.                 | Month  AGE (In years   IF UNDER 15 | PEAR   IF UNDER 24 HRS.                 |
|    | FI              | EMD/E ColoREA  D. USUAL OCCUPATION (Give kind of work done   | 7. MARRIED NEVER MARRIED 8. WIDDWED OIVDRCEO 5. | Tul. 6 1895  | lost birthdoy) Months I            | Doys Hours Min.                         |
| (  | dun             | me prost of werking life, even if retired)   | Domestic.                                       | 14 MQTHER'S MAIDEN NAME                                | CDU                                | NIRY? USA                               |
|    | 15.             | WAS DECEASED EVER IN U.S. ARMED FORCES?  |   |  | Address                            | nel                                     |
|    | (Ye             | es, no, or unkgown) (If yes give wor or dotes of   | 77/5  | oh. tal Records  | FASTON                             | INTERVAL BETWEEN                        |
|    |                 | PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (C  | Kight Middle Ler                                | rebral Ardery  | Thrombosis                         | DNSET AND DEATH                         |
|    |                 | Conditions, if ony, which gove nise to immediate couse (a), stating the underlying couse last.     | 0   |  |                                    | Yes in                                  |
| 0  | ATION           |  | NTRIBUTING TO DEATH BUT NOT RELATED TO TH       | HE TERMINAL DISEASE CONDITION GIVE                     | V IN PART 1(o)                     | 19. WAS AUTDPSY PERFORMED? YES NO       |
|    | L CERTIFICATION | 20o. ACCIDENT WAS UNDERLYING  OR CONTRIBUTING  CAUSE OF OEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 205. DESCRIBE HDW INJURY DCCURRED. (E           | inter noture of injury in Port I or Port               | II of item 18.)                    |   |
|    | MEDICAL         | 20c. TIME DF INJURY Month, Doy, Yeor<br>Hour o.m. 19<br>p.m. 19                                    | While of work of work of foctor                 | DF INJURY (Home, form, ry, street, office bldg., etc.) | (City or town) (Count              | ty) (Stote)                             |
|    |                 | 21. I certify that (I) (this hosp saw the deceased alive an 220. SIGNATURE                         | ital) attended the deceased fram                | death accurred at 5 % M                                |                                    |   |
|    |                 | 22c. PHYSICIAN'S S.  | ch M.D.   | ATTENOING MED. OIRECTOR  22d. ADDRESS                  | STAFF PHYS. D / O                  | 15/66                                   |
| 1  | 230.            | D. BURIAL, CREMATION, 23b. DATE THER   | EDF 23c. NAME DE CEMETERY DR CI                 | REMATORY 23d. LDC                                      | CATION (City or Town) (C           | County) (Stote)                         |
| 1  | 1               | REMOVAL (Specify)  1. FUNERAL DIRECTOR   | -66 St. Pauls C                                 | 2So. REC'D BY REGISTR.                                 | TAL                                | sot Md.                                 |
| B  |                 | max f Coll   | Der (1) as his Dal                              | DATEOCT 21   | 1966 Jelianl                       | es Judge                                |

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours ofter death.

Poge 4 moy be retoined by the hospital or ottending physicion.

VR A15 (4) 20 M 1/66

**TO FUNERAL DIRECTOR:** After this certificote hos been signed by the attending physician ond completely filled in by the funeral director, page 3 should be detoched for use as the burial-transit permit. Then please remove corbon papers. Pages 1 ond 2 should be filed with the State Dept. of Heolth prior to burial, cremotion, or removol, and in any event, within 72 hours after depths.



MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

| WARRY TO SERVICE OF THE PARTY O | 700. 1 | 533           | 14716                                 |   |                        | CERTI               | FICATE   | OF DEATH  |   | 1                             | 4718  |
|--|--------|---------------|---------------------------------------|---|------------------------|---------------------|----------|---|---|-------------------------------|---|
| requires that the death certificate be executed within 24 haurs after death g physician.  signed by the attending physician and campletely filled in by the funeral burial-transit permit. There phase cambon papers. Pages I and a burial, crematian, ar remanation any event, within 72 haurs after death  | Vi     |               | COUNTY                                | TAIbOT  |                        | MAR                 | RYLAND   | 2. USUAL RESIDENCE (Who                               | ere deceosed lived, if instit           | ution: Residence<br>UNTY      | e before odmission)<br>M202DWG                |
| be executed within 24 haurs after<br>and campletely filled in by the formove carbon papers. Pages<br>in any event, within 72 haurs after   |        |               | write RIIRAL ond                      | f outside corporate limits<br>give neorest town         |                        | c. LENGTH OF STAY   | IN 1b    |   | de corporote limits, write R            | URAL ond give                 | Lan.  |
| n 24 ha<br>illed in<br>papers.<br>in 72 h  | 18     |               | NAME OF HOSPITA                       | AL OR INSTITUTION (IF no                                | //                     | OSPITA              | 14       | d. STREET ADORESS                                     |   | 05.0                          | e. IS RESIDENCE<br>ON A FARM?<br>YES NO       |
| ecuted within 24<br>campletely filled<br>ave carban pape<br>y event, within 7  |        |               | NAME OF<br>DECEASED<br>Type or print) | WAL   | TER                    | ALBEK               | OT.      | BEHLKE  | OF<br>DEATH                             | 10                            | Doy Year<br>9 19 66<br>YEAR LIF LINDER 24 HRS |
| and camp<br>remave<br>n any eve  |        | S.            | m                                     | 6. COLOR OR RACE  | 7. MARRIED<br>WIDOWED  | NEVER MARRIE        |          | 8/15/1903   | 9. AGE (In yeors lost birthdoy) 63 yrs. |                               | Days Hours Min.                               |
| ate be   |        | duri          | agmost of working                     | (Give kind of work done<br>life, even iberired) UL      |                        | IND OF BUSINESS OR  | 2        |   | NOIS                                    | 12. CITIZ                     | ZEN OF WHAT                                   |
| g poys<br>Ther p<br>maver  |        |               | FATHER'S NAME                         |   | (38                    | HLKE                |          | 14. MOTHER'S MAIDEN NAM                               | H 1380                                  |                               | /   |
| that the death certifion.  by the attending pry transit permit. Then crematian, ar remay   |        |               | s, no, or unknown)                    | R IN U.S. ARMED FORCES?<br>(If yes give wor or dotes of | f service)             | SOCIAL SECURITY NO. |          | FORMANT B   | EALKE,                                  | BN                            |   |
| that the<br>an.<br>by the<br>transit p   |        |               | PART I. DEAT                          | H WAS CAUSED BY:  IMMEDIATE CAUSE (                     |                        |                     | ie s     | Reart &   | in Ouro                                 | = 004                         | ONSET AND DEATH                               |
| physicia<br>physicia<br>signed k<br>burial-tr<br>burial, c   |        |               | Conditions, if ony, rise to immediate | e couse (a)   | (b) (b)                | ortic.              | ster     | rosis   |   | 0.00                          | meest.  |
| e law rec<br>tending p<br>as been s<br>as the b<br>priar ta b  |        |               | stoting the under                     | lying couse   | (c)                    |                     |          |   |   |                               | Tio was autorsy                               |
| e house  | 0      | CERTIFICATION |                                       |   |                        |                     |          | E TERMINAL DISEASE CONDIT                             |   |                               | 19. WAS AUTOPSY PERFORMED? YES NO             |
| Dia Taba   |        |               |                                       | CAUSE OF DEATH<br>MEDICAL EXAMINER)                     |                        |                     |          | nter noture of injury in Por                          |   | 15                            | (6  |
| JING PHYS by the has (fter this ce be detache State Dept.  |        | MEDICAL       | Hour o.m<br>p.m                       | n. 19   | While of work          | k 🔲 ot work 🗀       | fortor   | OF INJURY (Home, form, y, street, office bldg., etc.) | 20f. (City or town)                     | (Coun                         |   |
| rtenol<br>ained b<br>OR: Afi<br>nauld b<br>h the Si  |        |               | 21. I certif                          | y that (I) (this has<br>eceased alive an                | pital) atten<br>10 — E | 19 <u>_66</u> ,     | and that | 0-7 , 194 death accurred at $4$                       | M, fram causes                          | , 19 <u>6</u><br>s and an the | e date stated abave                           |
| ital or attent<br>may be retained<br>RAL DIRECTOR: A<br>page 3 shauld<br>be filed with the   |        |               | 22c. PHYSICIAN'S                      |   |                        | Trever              |          | ATTENDING ME<br>PHYS. DIF                             | RECTOR PHYS.                            |                               | -10-66  |
| TO HOSPITAL Page 4 may 1 TO FUNERAL E director, pag shauld be fill   | 1      | 230           | NAME (Type)                           | Robert  |                        | ever, M.I           |          | CHATODY / I   | ton, Maryla                             |                               | County) (State)                               |
| TO HOSPI<br>Page 4 r<br>TO FUNER<br>director,<br>shauld b  |        | 6             | REMOVAL (Specify)                     | H OHO 1   | 2,1961                 | O VILL  ADDRESS     | AGE      | 2So. REC'D B  | SARAH                                   |                               | LE OHIO                                       |
| VR A15 (4)<br>20 M 1/66  |        | 1             | CHAR                                  | LEIV.M  | 00 KB                  | 3 DEN               | TON      | 430   | 1 3 1966                                | Weline                        | la Oudan                                      |

1 1 1 1

MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH death. PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission a. COUNTY o. STATE b. COLINTY after MARYLAND b. CITY OR TOWN (If autside corporate limits. c. LENGTH OF STAY IN 16 outside carparate limits, write RURAL and give nearest town papers. Pag hin 72 haurs write RURAL and give nearest town) d. STREET ADDRESS e. IS RESIDENCE ON A FARM? d. NAME OF HOSPITAL OR INSTITUTION (If not in haspital, give street address) 531 HIGH St. YES NO Y 3. NAME OF DATE OF DEATH First Middle Month Doy Year DECEASED 10 30 (Type or print) 19 event, S. SEX IF UNDER 1 YEAR 6. COLOR OR RACE 7. MARRIED NEVER MARRIED AGE (In years IF UNDER 24 HRS last birthday) Manths Days Hours GIVORCED and in any WIDOWED 10a. USUAL OCCUPATION (Give kind of work done 10b. KIND OF BUSINESS OR 12. CITIZEN OF WHAT 11. BIRTHPLACE (County & State, or foreign country) during most at working life, even if retired) COUNTRY 2 13. FATHER'S NAME MOTHER'S MAIDEN remava WAS DECEASED EVER IN U.S. ARMED FORCES? INFORMANT 16. SOCIAL SECURITY NO Address (Yes, ng, or unknown) (If yes give your ar dates of service) FASTON crematian, 18. CAUSE OF DEATH (Enter only one cause per ling for (a), (b), and (c). INTERVAL BETWEEN ONSET AND DEATH PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) DUE TO burial, Conditions, if ony, which gave rise ta immediate cause (a). DUE TO stating the underlying cause priar ta last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(0) WAS AUTOPSY far use Health CERTIFICATION PERFORMED? NO 20o. ACCIDENT WAS UNDERLYING 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) OR CONTRIBUTING CAUSE OF DEATH af (IF EITHER, NOTIFY MEDICAL EXAMINER) State Dept. 20c. TIME OF INJURY Month, Doy, Year 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Home, form, 20f. (City or town) (County) (State) Hour a.m. While Nat While foctory, street, office bldg., etc.) 19 at work at wark attended the deceased from 21 | certify \_ , that (I) (we) last 3 and that death occurred at & M, from couses and on the date stated above. saw the de 22a, SIGNATURE 22b. DATE SIGNED ATTENDING MED. DIRECTOR directar, page 3 shauld be filed PHYS. PHYS. PHYSICIAN'S NAME (Type NAME OF CEMETERY OR CREMATORY BURIAL, CREMATION 23b. DATE THEREOF 23d. LOCATION (City (State) (County) **ADDRESS** 5a. REC'D BY REGISTRAR 25b. REGISTRAR'S SIGNATURE 24. FUNERAL DIRECTOR VR A15 (4) 20 M 1/66 DATE NO

requires that the death certificate be executed within 24 haurs after deat the haspital ar attending TO FUNERAL DIRECTOR: After Page 4 may be retained by

Pages 1 and 2

filled in by the funeral

physician and campletely

remave

please

attending phys permit. Then p

permit.

burial-transit

use as the

detached

pe

shauld

signed by

this certificate has been

Will-i 

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
147211 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physican and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then physic remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death

|                 | JASTO CERTIFICATE OF DEATH   |
|-----------------|--|
| 1.              | PLACE OF DEATH  O. COUNTY  O. STATE  O. COUNTY  D. COUN |
| _               | Jacob MARYLAND MARYLAND CAROLINE   |
|                 | b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest fown)  c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest fown)   |
|                 | Sastous RURAS CENTERVINE   |
| -               | d. NAME OF HOSPITAL OR INSTITUTION (If no in hospital, give street address)  d. STREET ADDRESS  e. IS RESIDENCE ON A FARM?   |
|                 | allebaryal Hospilar 100 2 YES NO 10  |
|                 | NAME OF DECEASED (Type or print) To the less than 12 1966  |
| S.              | SEX 6. COLOR OR RACE 7. MARRIED NEVER MARVIED   B. DATE OF BIRTH 9. AGE (In years last birtholy) Months Days Hours Min.  |
|                 | b. USUAL OCCUPATION (Give kind of work done ring most of working life, even it retired)  10b. KIND OF BUSINESS OR  11. BIRTHPLACE (County & Stote, or foreign country)  12. CITIZEN OF WHAT  COUNTRY  COU |
| 13.             | FATHER'S NAME PREXANDER BORDIEY  14. MOTHER'S MAIDEN NAME PREXANDER BORDIEY  CAROLIVE RINGO  |
| 15.             | WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17. INFORMANT Address  |
| (1)             | es, no, or unknown) (If yes give wor or dotes of service) 140 Sph. RECORDS EASTON, Md  |
| -               | 18. CAUSE OF DEATH (Enter only one couse per the for (o), (b), and (c),  |
|                 | PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (0) Right Middle Cerebral Actory Thrombosis on 2 AND DEATHS.  |
|                 | 332 X DUE TO   |
|                 | Conditions, if ony, which gave (b)   |
|                 | stating the underlying couse DUE TO  |
|                 | last. (c)  |
| ATION           | PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)  19. WAS AUTOPSY PERFORMED? YES NO  |
| L CERTIFICATION | 20o. ACCIDENT WAS UNDERLYING  OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Part I or Port II of item 1B.)  |
| MEDICAL         | 20c. TIME OF INJURY Month, Doy, Year Hour o.m. p.m. 19 20d. INJURY OCCURRED While of work of work Not While of work  |
|                 | 21. I certify that (1) (this haspital) attended the deceased fram 10 12, 1900 ta 10 13, 1900, that (1) (we) last   |
|                 | saw the deceased alive an 10 / 13 1966, and that death accurred at 3 M, fram causes and an the date stated above.  |
|                 | Sur ind decessed and an analysis and the dute stated above.  |
|                 | 220. SIGNATURE  M.D. ATTENDING MED. STAFF 22b. DATE SIGNED CO. 151 6 6   |
|                 | 220. SIGNATURE ATTENDING MED. STAFF 22b. DATE SIGNED   |
| 2               | 220. SIGNATURE    C   M.D.   ATTENDING   MED.   STAFF   22b. DATE SIGNED   |
| 2               | 220. SIGNATURE  220. SIGNATURE  M.D. ATTENDING MED. STAFF 22b. DATE SIGNED  22c. PHYS. CIAN'S NAME (Type) S. KECH, TR. 22d. ADDRESS Castur, Med. (O/15) C. STAFF (O/15) C. STA |

O HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

VR A15 (4) 20 M 1/66

to the property of the propert

O SULTAL RELIEF

98111

2114

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

|               | 1471  | 5   | Line is                     | CERTIFICA                                | TE OF                | DEATH                                     |                        |  | 14            | 722                       | 2                                    |
|---------------|---|---|-----------------------------|--|----------------------|---|------------------------|--|---------------|---------------------------|--------------------------------------|
|               | COUNTY  | bot   |                             | MARYLAND                                 | 0. 5                 | TATE Mary 1                               | and                    | b. COU                                 | Care          | oline                     |                                      |
|               | write RURAL one   |   | 17,000                      | t. LENGTH OF STAY IN 16                  |                      |   | tside corporote        |  | JRAL ond give | neorest                   | town)<br>5・ユ                         |
| d             | I. NAME OF HOSPIT.  | at or institution (if no morigal                          | ot in hospitol,             | give street oddress)                     | d. STR               | Libe                                      | rty Roa                | ad                                     |               | e.<br>YE                  | IS RESIDENCE<br>ON A FARM?<br>S NO X |
| (             | NAME OF<br>DECEASED<br>Type or print)   | wil   | est<br>Eleán                | Edward                                   |                      | Imlas                                     | 4. DATE<br>OF<br>DEATH | Mon                                    | 7 -           | Doy<br>OO                 | Year<br>19 66                        |
| 5. S<br>M     | iale  | 6. COLOR OR RACE White                                    | 7. MARRIED<br>WIDOWED       | NEVER MARRIED DIVORCED                   |                      | of BIRTH 7, 1912                          |                        | AGE (In yeors<br>ost birthdoy)<br>yrs. | Months 1      |                           | Hours Min.                           |
| durir<br>Pi   | lling Ro  | (Give kind of work done life, even if retired) om Foreman | IN                          | IND OF BUSINESS OR IDUSTRY  Yland Plasti | cs I                 | enton Nother's MAIDEN N                   | Marvlar                |  | (01           | IZEN OF V<br>UNTRY?<br>SA | VHAT                                 |
| 13.           | FATHER'S NAME William   | E. Chamber  | rs, Sr.                     | ,  |                      | lorence                                   |                        | 2                                      |               |                           |                                      |
| 15.<br>(Yes   | WAS DECEASED EVE<br>s, no 8 unknown)  | R IN U.S. ARMED FORCES?<br>(If yes give wor or dotes o    | f                           |  | 7. INFORMA<br>Gladys | M.Chamb                                   | pers, I                | Addr<br>Federals                       |               | Mar                       | yland                                |
|               | PART I. DEAT  H 2 0 1  Conditions, if ony, rise to immediat stoting the under last. | e couse (o),<br>lying couse                               | (o) TO (c)                  | cule m                                   | joen                 | dral                                      | inf                    | enter                                  | J             | ONSE                      | VAL BETWEEN<br>T AND DEATH           |
| CERTIFICATION | 20o. ACCIDENT WAS   | UNDERLYING  |                             | SCRIBE HOW INJURY OCCURR                 |                      |   |                        |  |               | 19. W<br>PI<br>YES        | AS AUTOPSY ERFORMED?                 |
| MEDICAL       |   | RY Month, Doy, Yeor                                       | 20d. If<br>While<br>of work | Not While                                |                      | URY (Home, form,<br>, office bldg., etc.) | , 20f.                 | (City or town)                         | (Cou          | nty)                      | (Stote)                              |
|               | 21. I certif  | y that (I) (this has becased alive an_                    | Plan                        | ded the deceased fram                    | hat death            | accurred at_                              | MED. DIRECTOR C        | fram causes  STAFF PHYS.               | and an th     | c than date of the signed | 0                                    |
|               | BURIAL, CREMATIO<br>REMOVAL (Specify)   | Oct. 23   |                             |  |                      | erv                                       | Feder                  | TION (City or To                       | g, Car        |                           |                                      |
| 24.           | FUNERAL DIRECTO   | + 7   | - 1                         | How Tele                                 | 00                   |   | BY REGISTRAF           |  | Clas          |                           | Judge                                |

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove corban papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremotion, or removal, and in any event, within 72 hours ofter death. TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death Poge 4 moy be retained by the hospitol or ottending physician. VR A15 (4) 20 M 1/66

14722 banky and awadafayo bal new waveful the first and the first last the second and the first ATS AND MISS . - IT IN PART THE SECOND OF SHARE SECOND SECOND Course Steeless F. Strage, M. J. vell Blacker, Val. .bi mullore, 23, 1966, usti crear (reserve de la constitución de la co

MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
Them #2a.b.c. & d infor. taken from birth cert.

| . (   |            | 14720 CERTIFICATE   | OF DEATH   | 723                                      |
|---|------------|---|--|--|
| uneral<br>I one   | Ī          | PLACE OF DEATH  | 2. USUAL RESIDENCE (Where deceosed lived, if institution: Residence o. STATE b. COUNTY |  |
| fun   | L          | MARYLAND  | MQ.  | 2.A.                                     |
| a a a   |            | b. CITY OR TOWN (If outside corporate limits, write RURAL and give neorest town)  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give                     | nearest tawn)                            |
| क्षेत्र के जिल्ह  |            | -45 70 N 2 days   | Grasonville  | 17-2                                     |
| ho in 2 H   |            | d. NAME OF HOSPITAL OR INSTITUTION (If nat in hospital, give street address)  | d. STREET ADDRESS  | e. IS RESIDENCE<br>ON A FARM?            |
| filled in<br>papers,<br>thin 72 H   | 8          | MEMORIAL HOSPITAL   | Graveyard Lane   | YES NO                                   |
| e executed within 2<br>and completely fille<br>remove corbon par<br>n ony event, within | 3          | NAME OF DECEASED (Type or print)  BABV GIRX   | LARK DEATH 10  | Doy Year 1966                            |
| mp ve c   | 5          | SEX 6. COLOR OR RACE 7. MARRIED NEVER MARRIED   |  | YEAR IF UNDER 24 HRS.<br>Days Haurs Min. |
| exected colony  |            | + COL WIDOWED DIVORCED  | 10/14/66 Yrs.  | 2  |
| ian on  | 11<br>d    | Do. USUAL OCCUPATION (Give kind of work done uring most of warking life, even if retired)  1Db. KIND OF BUSINESS OR INDUSTRY        |  | ZEN OF WHAT<br>NTRY?                     |
| th certifico<br>Jing physic<br>Then plan<br>removal                                     | 1          | 3. FATHER'S NAME Isaac Clark  | 14. MOTHER'S MAIDEN NAME Wyvette Mocre   |  |
| en en or  | (          | S. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, na, or unknawn) (If yes give wor ar dotes of service) 16. SOCIAL SECURITY NO. 17. 1 | NFORMANI<br>vette Clark, Mother, Grasonvil   | le, Md.                                  |
| that the dan. by the ott transit per  |            | 1B. CAUSE OF DEATH (Enter only one couse per line for (o), (b), and (c).)   |  | INTERVAL BETWEEN                         |
| at 1<br>h th<br>nsit  |            | PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)  | s Premenia   | ONSET AND DEATH                          |
|   |            | 3402 DUE TO /   | 1 1 11   | cl.                                      |
| equires<br>physici<br>signed<br>burial-<br>burial,                                      | -          | Canditions, if ony, which gove rise to immediate couse (a),   | cn) rgo oncella 15715  | 81149,                                   |
| 0)  |            | stating the underlying cause DUE TO   |  |  |
| e low re<br>tending<br>is been<br>os the<br>prior to                                    |            | last. (c)   |  |  |
| he ho   | 2 VALION   | PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO 1  |  | 19. WAS AUTOPSY PERFORMED? YES NO        |
| 三 4 海 一   | CEDITICION |   | Enter noture of injury in Part 1 or Port II of item 18.)                               |  |
| IG PHYSIC<br>the hospi<br>r this cert<br>detoched<br>ate Dept. o                        | MEDICAL    | 20c. TIME OF INJURY Month, Day, Yeor Hour a.m. p.m. 19 20d. INJURY OCCURRED 40e. PLACE factors of work at wark 19                   | E OF INJURY (Home, form, ary, street, office bldg., etc.) 20f. (City or town) (Cour    | nty) (State)                             |
| Afte be Sto   |            | 21. I certify that (I) (this hospital) attended the deceased from   |  | _, that (I) (we) last                    |
| R: A  |            | saw the deceased alive an19, and that   | death accurred at 10 p M, fram causes and an the                                       |  |
| OR ATTER<br>be retaine<br>DIRECTOR:<br>ge 3 shoul<br>led with th                        |            | 220 SIGNATURE CONCERNATION MEN CONCERNATION M.C.  | D. ATTENDING MED. STAFF DIRECTOR PHYS. D / O   | TE SIGNED                                |
| AL AL POG   |            | 22c. PHYSICIAN'S NAME (Type) Robert M. McDonald, M.D.   | 22d. ADDRESS<br>A Hanson Sty Faston  | n, Md                                    |
| Page 4 m<br>Funer<br>director,<br>should b  | 2          | 30. BURIAL, CREMATION, 23b. DATE THEREOF 23c. NAME OF CEMETERY OR   | REMATORY 23d. LOCATION (City or Town)  | County) (Stote)                          |
| Page O FUN direct shoul   | Th         | REMOVAL (Specify) ceneration 10/24/66 Memorial Hos  | pital Easton, Maryland   |  |
|   |            | 24. FUNERAL DIRECTOR ADDRESS  | 250. REC'D BY REGISTRAR 25b. REGISTRAR'S SIG   |  |
| VR A15 (4)<br>20 M 1/66   | IV.        | emorial Hospital, Easton, Maryland  | DATE OV 1 1966 Jolians   | & Judge                                  |
|   |            | 6-237715  |  | 0  |

1.5% The state of the Country of the State of the

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

| (IVI)   |                 | 14721  | CERTIFICAT                                   | E OF DEATH   |  | 14724   |
|---|-----------------|--|--|--|--|---|
| leose remove carbon papers. Pages 1 ond ond in any event, within 72 hours ofter death |                 | PLACE OF DEATH 1. COUNTY TALOOT  | MARYLAND                                     |  | (Where deceosed lived, if institution b. COUNTY) | ion: Residence before odmission) NTY Caroline         |
| offe  |                 | o. CITY OR TOWN (If outside carporote limits,  | c. LENGTH OF STAY IN 1b                      | c. CITY OR TOWN (If a  | utside corporate limits, write RUF               |   |
| Pag   |                 | write RURAL and give nearest town  | 21   | Ri   | dgely  | 05.2  |
| 2 ho  |                 | . NAME OF HOSPITAL OR INSTITUTION (If not in   |  | d. STREET ADDRESS  |  | e. IS RESIDENCE                                       |
| E 78  |                 | Memorial   | tosp tal                                     |  | None   | ON A FARM? YES NO                                     |
| П, УИП.   |                 | NAME OF First DECEASED Type or print)  | in Middle                                    | Colanin  | 4. DATE Manti<br>OF<br>DEATH C                   | h Day Year<br>28 1966                                 |
|   | S               | 77 7 7777  | MARRIED NEVER MARRIED NEVER MARRIED DIVORCED | B. DATE OF BIRTH   | 9. AGE (In years last birthday)<br>88 yrs.       | Months Days Haurs Min.                                |
|   | 10a.<br>duri    | USUAL OCCUPATION (Give kind af work dane ne most of warking life even if retired)  | 10b. KIND OF BUSINESS OR INDUSTRY            |  | y & State, or foreign country)                   | 12. CITIZEN OF WHAT COUNTRY?                          |
|   | _               | FATHER'S NAME  |  | 14. MOTHER'S MAIDEN  |  | 1 OUR   |
|   |                 | Thomas Mitch   | hell   | Sadie 3  | Parris   |   |
|   | 15.             | WAS DECEASED EVER IN U.S. ARMED FORCES?  | 16. SOCIAL SECURITY NO. 17.                  | INFORMANT  | Addre  | ess   |
|   | (16             | TO   | 215-20-4256                                  | Norris B   | utler Ridgel                                     | v. Maryland   |
|   |                 | 1B. CAUSE OF DEATH (Enter only one cause part 1. DEATH WAS CAUSED BY:  IMMEDIATE CAUSE (a).  Canditions, if any, which gove nise ta immediate cause (a), stating the underlying couse  (c) | acute myo                                    | cardial  | ation<br>Inforct<br>eart disea                   |   |
| 0   | ATION           | PART II. OTHER SIGNIFICANT CONDITIONS CONT   | RIBUTING TO DEATH BUT NOT RELATED TO         | ) THE TERMINAL DISEASE CO                                      | NOITION GIVEN IN PART 1(0)                       | 19. WAS AUTOPSY PERFORMED? YES NO                     |
|   | L CERTIFICATION | 20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   | 205. DESCRIBE HOW INJURY OCCURRED            | ). (Enter noture of injury in                                  | Port I or Port II af item 18.)                   |   |
|   | MEDICAL         | 20c. TIME OF INJURY Month, Day, Year<br>Haur a.m.<br>p.m. 19   |  | LACE OF INJURY (Hame, far<br>octory, street, affice bldg., etc | .)   | (Caunty) (State)                                      |
|   |                 | 21. I certify that (I) (this haspite   | al) attended the deceased fram_              |  | 19, ta   | , 19, that (I) (we) la<br>and an the date stated abov |
|   |                 | saw the deceased alive an 10   | -28 19 <u>66</u> , and th                    | at death accurred a  | M, fram causes                                   |   |
|   |                 | 22a. SIGNATURE Robert W  | 1. Trever                                    | M.D. ATTENDING PHYS.   | MED. STAFF PHYS.                                 | 22b. DATE SIGNED                                      |
| / /   |                 | 22c. PHYSICIAN'S<br>NAME (Type)  |  | 22d. ADDRESS   |  |   |
|   | 23a             | BURIAL, CREMATION, 23b. DATE THEREC  | OF 23c. NAME OF CEMETERY O                   | R CREMATORY  | 23d. LOCATION (City or Tov                       | , , , , , ,   |
| R   |                 | The state of the Columbia  | 31,66 Greensho                               | ro   | Greensbor  |   |
| 0   | 24              | FUNERAL DIRECTOR   | ADDRESS                                      |  | D BY REGISTRAR 25b. REG                          | GISTRAP'S SIGNATURE QUESE                             |

STAL

funeral and 2 death. the fi Page hours = filled in papers. within etely pou event, carl compl and con any ferding physician a life. Then please re or femoval, and in Ξ 0 transit per cremation n signed by burial-transit burial, crema physician. been the r attending as th use certificate hospital or 5 this certing detached for retained DIRECTOR: 3 sho be 8 page may Page !

death.

after

hours

24

withIn

executed

pe

certificate

death

that the

requires

The law

PHYSICIAN:

ATTENDING

O HOSPITAL

a. COUNTY a. STATE Talbox MARYLANO b. CITY OR TOWN (if outside corporate limits, c. LENCTH OF STAY IN 1b write RURAL and give nearest town) hunch Hill Wears d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) for foed Women Home NAME OF Middle DATE Last **DECEASED** Leveland (Type or print) ook DEATH 6. COLOR OR RACE 7. MARRIED NEVER MARRIEO temale WIDOWED DIVORCED 10a. USUAL OCCUPATION (Give kind of work done | 10b. KIND OF BUSINESS OR during most of working life, even if retired) Queen Anne ousework 13. FATHER'S NAME 14. MOTHER'S MAJOEN NAME Martha E. William Thomas Sener /autor 15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO 17. INFORMANT (Yes, no, or unkown) (If yes give war or dates of service) Miss Ruth Hollecker CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c), ] PART I. OEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) DUE TO Conditions, If any, which gave rise to immediate DUE TO cause (a), stating underlying cause last. (c) CERTIFICATION 20a. ACCIDENT WAS UNDERLYINC ☐ OR CONTRIBUTING ☐ CAUSE OF OEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) MEDICAL 20c. TIME OF INJURY Month, Day, Year 20d. INJURY OCCURRED | 20e. PLACE OF INJURY (Home, farm, should be der Hour a.m. factory, street, office bldg., etc.) While Not While p.m. at work at work 21. I certify that (I) (this hospital) attended the deceased from\_ saw the deceased alive on 19.66. and that death occurred at 22a. SICNATURE ATTENDING PHYS. MED. DIRECTOR TO FUNE...
director, pr PHYSICIAN'S 22d. ADDRESS NAME (Type) D 23a. BURIAL, CREMATION, 23b. DATE THEREOF NAME OF CEMETERY OR CREMATORY REMOVAL (Specify) 1966 hurch Hi Durial emeteru REGISTRAR

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH PLACE OF DEATH USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission, b. COUNTY ucen Anne c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) e. IS RESIDENCE ON A FARM? NO C YES Month Day Year 19 1966 ACE (In years | IF UNDER 1 YEAR | IF UNDER 24 HRS last birthday) Months | Oays Hours 11. BIRTHPLACE (County & State, or foreign country) 12. CITIZEN OF WHAT COUNTRY? Manuland Easton, Ad. INTERVAL BETWEEN ONSET AND DEATH Uncertain PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION CIVEN IN PART 1(a) WAS AUTOPSY PERFORMED? NO F YES DESCRIBE HOW INJURY OCCURRED, (Enter nature of injury in Part I or Part II of Item 18.) 20f. (City or town) (State) (County) 1961 to 10-19 1966, that (I) (we) last M. from the causes and on the date stated above. 22b. DATE SICNED STAFF -20-66 10 Faston Md. LOCATION (City, town or county) (State) 25b. REGISTRAR'S SIGNATURE Melarles 1966 aston.

MARYLAND STATE DEPARTMENT OF HEALTH

VR A.15 (4) 20M 1/65

erion funcial total

18841

Total and the state of the stat

The same two stands

Acada chitte

277 - 8293

7/2/2/

File a Lieuwa and a w

the control of the second of the control of the con

AND THE RESERVE OF THE PARTY OF

- we sail - 1822 to 6 (Juno) will construe to make the total

executed within 24 hours after death. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate. Page 4 may be retained by the hospital or attending physician.

VR AI5 (4) 20M 1/65

| DIVISION OF STATIST | MARYLAND STAT | E DEPARTMENT OF HEALTH<br>CORDS, 301 W. PRESTON STREET,<br>CATE OF DEATH | BALTIMORE 1, MARYLAND                       |
|---------------------|---------------|--|---|
| 14723               | CERTIFI       | CATE OF DEATH  | 14726                                       |
| LACE OF DEATH       |               | 2. USUAL RESIDENCE (Where plecease                                       | sed lived, If institution: Residence before |

| 1. PLACE OF DEATH  | 2. USUAL RESIDENCE (Where deceased lived, If institution; Residence before admission) |
|--|---|
| a. COUNTY TA/BOT MARYLAND  | a. STATE MARYLAND b. COUNTY TALLANT   |
| b. CITY OR TOWN (if outside corporate limits,   c. LENCTH OF STAY IN 1b  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)      |
| write RURAL and give nearest town)   | Deal Task Duille  |
| RURAL EASTON LIFE  | KURAI EASTON ROYOLCAN   |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)   | d. STREET ADDRESS  6. 18 RESIDENCE ON A FARM?   |
|  | YES NO  |
| 3. NAME OF First Middle  | Last Month Day Year   |
| (Type or print) ARTHUR JACOT   | COENISH DEATH 10 5 1966   |
| 5. SEX   6. COLOR OR RACE   7. MARRIED   NEVER MARRIED   | 8. OATE OF BIRTH 9. ACE (In years   IF UNDER 1 YEAR   IF UNDER 24 HRS.                |
| MA/S COLORED WIDOWED OVORCED   | 12-30-1884   last birthday) Months Oays Hours Min.                                    |
| 10a. USUAL OCCUPATION (Give kind of work done   10b. KIND OF BUSINESS OR   | 11. BIRTHPLACE (County & State, or foreign country)   12. CITIZEN OF WHAT             |
| during most of working life, even If retired) INDUSTRY   | Tolbet my COUNTRYT/54   |
| 13. FATHER'S NAME  | 14. MOTHER'S MAIOEN NAME  |
| Man Ocher To have said   | To Do Casallo b   |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES?   16. SOCIAL SECURITY NO.   17.  | JANE 11. CORNISTI   |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES?   16. SOCIAL SECURITY NO.   17. (Yes, no, or unknown)   (If yes give war or dates of service)   17.  | INFORMANT   |
| NO 213-26-3241 1   | BENTHEY KOVALLAR, INC   |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]  | INTERVAL BETWEEN  |
| PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)   | ONSET AND DEATH   |
| (000   | 7.11  |
| Cenditions, If any, which \ DUE TO \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \   | (Let out hilling 12 VI  |
| gave rise to Immediate   | grander   |
| cause (a), stating the OUE TO  |   |
| underlying couse last.   |   |
| PART IF OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT HOT REL   | AFED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) 19. WAS AUTOPSY PERFORMED?  |
| 5 Muranus Trilly   | SIGNIFIC YES NO [   |
| 203 ACCIDENT WAS UNDERLYING 208. DESCRIBE HOW INJURY OCC   | URREO. (Enter nature of injury in Part I or Part II of Item 18.)                      |
| PART I OTHER SICNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT HOT RELIEF TO THE CONTRIBUTION T |   |
|  | ACE OF INJURY (Home, farm, 20f. (City or town) (County) (State)                       |
| Hour a.m. While Not While  | ory, street, office bldg., etc.)  |
|  | Alexander State of the second   |
| 21. I certify that (I) (this hospital) attended the deceased from 2  | 1900, to 000, 1900, that (1) (we) last  |
|  | t death occurred at M. from the causes and on the date stated above.                  |
| 22a SIGNATURE  | ATTENOING MED. STAFF 22b. DATE SICNED   |
| 1-VIUMI I/RUMA M.I   | O. PHYS.   OIRECTOR   PHYS.   10  |
| 22c. PHYSICTAN'S<br>NAME (Type)  | 22d. AODRESS  |
| Triant (1)poy  |   |
| 23a. BURIAL, CREMATION, 23b. DATE THEREOF   23c NAME OF CEMETER  | Y OR CREMATORY   23d. LOCATION (City, town or county) (State)                         |
| BURGO (Specify) 10-10-66 ROVAL (VE   | of Com, Total Md  |
| 24. FÜNERAL DIRECTOR / ADDRESS   | 25a. REC'D BY REGISTRAR   25b. REGISTRAR'S SICNATURE                                  |
| James R Na. 1.00 Papilon   | That word 1 1 1966 Melando Oude   |
| JUNIOS BINGSPILLY OUSIVE   | DATE UC 1 1966 Cuartes Juage  |

#\$141

consideration and a section of the section that

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physican and campletely filled in by the funeral director, page 3 shauld be detached far use as the burial-transit permit. Then please remave carban papers. Pages 1 and 2 shauld be filed with the State Dept. af Health priar ta burial, crematian, ar remaval, and in any event, within 72 haurs after death. O HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 haurs after death. Page 4 may be retained by the haspital ar attending physician.

> VR A15 (4) 20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

| NAME OF DECEASED (Type or print)  S. SEX  6. COLOR OR RACE  7. MARRIED  NEVER MARRIED  DIVORCED  DIVORCED  DIVORCED  S. DATE OF BIRTH  ORALLE  C. LORG C. WIDOWED  DIVORCED  DIVORCED  DIVORCED  S. DATE OF BIRTH  ORALLE  C. LORG C. WIDOWED  DIVORCED  DIVORCED  S. DATE OF BIRTH  ORALLE  C. LORG C. WIDOWED  DIVORCED  DIVORCED  S. DATE OF BIRTH  ORALLE  C. LORG C. WIDOWED  DIVORCED  S. DATE OF BIRTH  ORALLE  C. LORG C. WIDOWED  DIVORCED  S. DATE OF BIRTH  ORALLE  C. LORG C. WIDOWED  DIVORCED  S. BIRTHPLACE (Country & State, or rareign country)  I.S. MANDERS MAJORE NAME  I.S. WAS DECEASED PYRE IN US. ARMED FORCES.  (Yes, no. or runnom)  (If ye sign was or address of service  I.S. WAS DECEASED PYRE IN US. ARMED FORCES.  (Yes, no. or runnom)  III S. CAUSE OF DEATH (Enter only one course per law Ser [s], (b), and (c))  PART I.DEATH WAS CAUSED DY:  III CAUSE OF DEATH (Enter only one course per law Ser [s], (b), and (c))  PART I.DEATH WAS CAUSED DY:  III CAUSE OF DEATH (Enter only one course per law Ser [s], (b), and (c))  PART I.DEATH WAS CAUSED DY:  III CAUSE OF DEATH (Enter only one course per law Ser [s], (b), and (c))  PART I.DEATH WAS CAUSED DY:  III CAUSE OF DEATH (Enter only one course per law Ser [s], (b), and (c))  PART I.DEATH WAS CAUSED DY:  III CAUSE OF DEATH (Enter only one course per law Ser [s], (b), and (c))  PART I.DEATH WAS CAUSED DY:  III CAUSE OF DEATH (Enter only one course per law Ser [s], (b), and (c))  TO USE TO USE TO USE OF DEATH (Enter only one course per law Ser [s], (b), and (c))  TO USE TO USE TO USE OF DEATH (Enter only one course per law Ser [s], (b), and (c))  III CAUSE OF DEATH (Enter only one course per law Ser [s], (b), and (c))  TO USE TO US | 14724  | CERTIFICAT                    | E OF DEATH               |                       | 14727                                   |
|--|--|-------------------------------|--------------------------|-----------------------|---|
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street oddress)  d. STREET ADDRESS  d. STREET ADDRESS  v. IS REST.  A DATE OF PECKAS OF INTITUTION (If not in hospital, give street oddress)  3. NAME OF PECKAS OF INTITUTION (If not in hospital, give street oddress)  3. NAME OF OF PECKAS OF INTITUTION (If not in hospital, give street oddress)  3. NAME OF OF INTITUTION (If not in hospital, give street oddress)  3. NAME OF OF INTITUTION (If not in hospital, give street oddress)  3. NAME OF OF INTITUTION (If not in hospital, give street oddress)  3. NAME OF OF INTITUTION (If not in hospital, give street oddress)  4. DATE OF OF INTITUTION (If not in hospital, give street oddress)  4. DATE OF OF INTITUTION (If not in hospital, give street oddress)  4. DATE OF OF OF INTITUTION (If not in hospital, give street oddress)  4. DATE OF OF OF INTITUTION (If not in hospital, give street oddress)  5. NAME OF OF INTITUTION (If not in hospital, give street oddress)  6. COLOR OR RAKE IT, MARKING INDONE IN HOSPITAL (IN HOSPITAL IN HOSPITAL IN HOSPITAL (IN HOSPITAL IN HOSPITAL IN HOSPITAL IN HOSPITAL (IN HOSPITAL IN HOSPITAL IN HOSPITAL IN HOSPITAL IN HOSPITAL (IN HOSPITAL IN HOSPITAL  |  | MARYLAND                      | o. STATE MD              | b. COUNTY             | AhhoT                                   |
| 3. NAME OF DECEASED   CONTROLLING   FIRST   CONTRIBUTING   DEATH   SUNDERLYING   CONTRIBUTING    | write-RURAL and give negrest tawn)                         | 2 days                        | ST. MIC                  | 1 1 .                 | give nearest tawn)                      |
| DECEASED (Type or point) (Type | Memorial Ho  | aspital, give street address) | d. STREET ADDRESS        |                       | e. IS RESIDENCE<br>ON A FARM?<br>YES NO |
| DIVORCED    | DECEASED (Type or print) CORINC                            | Geetrude                      | DIXON OF DEAT            | H Oct                 | 14 19 66                                |
| INDUSTRY    | TEMALE COLORED WI  | DOWED DIVORCED                | Jan 9 1896               | last birthday) Manths | Days Hours Min.                         |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES?   (Yes, no, or unknown)   (If yes give war or dotes of service)   16. SOCIAL SECURITY NO.   17. INFORMANT   17.    | during most af warking life, even if retired)              |                               | marion S                 | areign country) 12.   |   |
| (Ves, no, or unknown) (If yes give war ard dates of service)    IB. CAUSE OF DEATH (Enter only one cause per June for (pt., (b), and (c))   PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)   DUE TO   Stating the underlying cause (a)   Stating the underlying cause (b)   Stating the underlying cause (b)   Stating the underlying Cause (b)   DUE TO   DUE T | Grant Wh   | nte                           | milkie à                 | Lloyd.                |   |
| PART I. DEATH WAS CAUSED BY:  IMMEDIATE CAUSE (a)  DUE TO  Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause lost.  DUE TO  (c)  PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)  PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)  19. WAS AUTO PERFORME YES  PERFORME YES  NO  | (Yes, na, ar unknawn) (If yes give war ar dates af service | (e)                           |                          | It miche              | eli. Ind                                |
| Conditions, if any, which gave inse to immediate cause (a), stating the underlying cause last.  PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)  20. ACCIDENT WAS UNDERLYING CONTRIBUTING CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)  20. ACCIDENT WAS UNDERLYING CONTRIBUTING CONTRIBUTION CONTRIBU | PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)           | like for (p), (b), and (c).   | Mercula                  | o accepting           | ORSET AND DEATH                         |
| Stand   County   Stand   County   Cou   | Conditions, if any, which gave                             | Trutheope                     | lerolie (M               | Allende               | Byr.                                    |
| 200. ACCIDENT WAS UNDERLYING  OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  200. TIME OF INJURY Manth, Day, Year Haur a.m. 19   | last. (c)  |                               |                          |                       | 1/                                      |
| OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  20c. TIME OF INJURY Manth, Day, Year Haur a.m. p.m.  19   | ATIO   |                               |                          |                       | PERFORMED?                              |
| 21.   Certify that (I) (this haspital) entended the deceased from  | OR CONTRIBUTING CAUSE OF DEATH                             |                               |                          | ort II af item 1B.)   |   |
| say the deceased alive on A and that death accurred at AM, fram causes and an the date stated  22 SIGNATURE  M.D. ATTENDING MED. STAFF DIRECTOR PHYS. DIRECT | p.m. 17  | While at wark fac             |                          | (City or town) (I     | county) (State)                         |
| ATTENDING M.D. ATTENDING DIRECTOR STAFF DIRECTOR | says the deceased alive on                                 | attended the deceased from 2  | at death accurred at 103 |                       |   |
| NAME (Type) R. Lane Wroth, M.D. St. Michaels  23a. BURIAL, CREMATION, REMOVAL (Specify) Of 17 1966 Thomas MENDRAL ST. MICHAELS MAR  24 FUNERAL DIRECTOR ADDRESS 25a. RECUBERARY 25b. REGISTRARY SIGNATURE)   | 1 March 1  | rolly "                       | .D. PHYS. DIRECTOR       | STAFF                 | 0-15-66.                                |
| REMOVAL (Specify) Oct 17 1966 Thomas MEMORIAL ST. MICHRELS MAR 24 FUNERAL DIRECTOR 250. REGISTRAR'S SIGNATURE)   | NAME (Type) R. Lane Wro                                    |                               | St. Michae               | ls                    |   |
|  | POURIAL Oct 1719   | 166 Thomas ME                 | EMIDRIAL 2               | T. MICHAEL            | S MARYLAN                               |
| Hampelon Harrison, St. Mckalbare Ol 19 1900 for  | Hampleton Ha   | rrison, St. N                 | vekenbare OCT 1          | 1966 FEGISTRAR'S      | signatur Judge                          |

Company of the Compan

## MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH 2. USUAL RESIDENCE (Where deceosed lived, if institution; Residence PLACE OF DEATH before odmission) o. COUNTY COUNTY-MARYLAND CITY OR TDWN (If outside corporate limits, c LENGTH OF STAY IN 1h c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) write RURAL and give nearest town) e. IS RESIDENCE ON A FARM? d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street oddress) d. STREET ADDRES YES NO T 3 NAME OF Middle 4 DATE Month First Dov Year DECEASED

(Type or print) S SEX IF UNDER 1 YEAR 6. COLOR OR RACE NEVER MARRIED AGE (In years IF UNDER 24 HRS 7. MARRIED lost birthdoy) Months Davs Hours WIDOWED DIVORCED 10o. USUAL OCCUPATION (Give kind of work done 10b. KIND OF BUSINESS OR 12. CITIZEN OF WHAT 11. BIRTHPLACE (County & Stote, or foreign country) during most of working life even if retired) INDUSTRY RETIRED FARMER FARMINA 13. FATHER'S NAME Udle WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. INFORMANT (Yes, no, or unknown) (If yes give war or dotes of service) -074-9 215-38 UES CAUSE OF DEATH (Enter only one couse per line for (o), (b), and (c). NTERVAL BETWEEN PART I. DEATH WAS CAUSED BY ONSET AND DEATH IMMEDIATE CAUSE (o) - DUE TO Conditions, if ony, which gove (b) rise to immediate couse (a) DUE TO stoting the underlying couse

CERTIFICATION 20o. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20c. TIME OF INJURY Month, Day, Year

Hour o.m.

20d. INJURY OCCURRED Not While

ot work

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(0)

20e. PLACE OF INJURY (Home, form, foctory, street, office bldg., etc.)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port II of item 18.)

(City or town)

. ta

(County) (Stote)

that (I) (we) last

19. WAS AUTOPSY PERFORMED?

NO

attended the deceased fram 21. I certify that saw the deceased alive 22o. SIGNATURE

and that death accurred at 549 **ATTENDING** M.D. PHYS.

DIRECTOR

19

M, fram causes and an the date stated above. 22b. DATE SIGNED

230. BURIAL, CREMATION, REMOVAt (Specify) BURIA

22c. PHYSICIAN'S

NAME (Type)

23c. NAME OF CEMETERY OR CREMATORX

23d. LOCATION (City or Town)

VR A15 (4) 20 M 1/66

director, page 3 should be filed v

death.

within 72 hours

and in any

cremat

burial,

Health r

0 detached

State

3 should be

burial-transit

signed by physician.

> this certificate Por

O FUNERAL DIRECTOR: After

Page 4 may

attending as the has been

be retained by the hospital or

OR ATTENDING

physician and completely filled in by the funeral

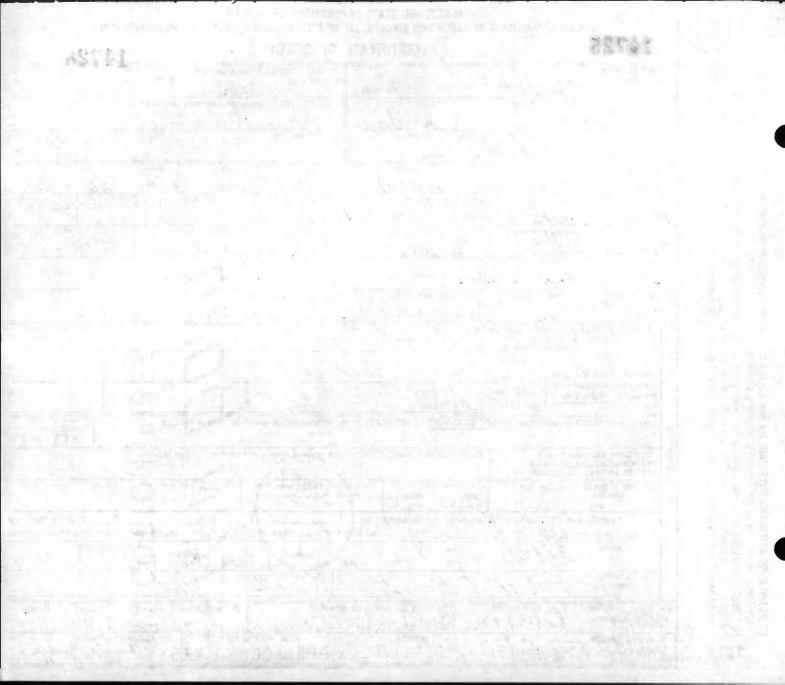
the attending parties in the

law requires that the death certificate be executed within 24 hours after death

last.

2So. REC'D BIT REGISTRAR

2Sb. REGISTRAR'S SIGNATURE



TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or temoval, and in any event, within 72 hours after death. TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
14726
CERTIFICATE OF DEATH
14729

|  | 111  |  |
|--|--|--|
| 1. PLACE OF DEATH a. COUNTY  | 2. USUAL RESIDENCE (Where deceased lived, If institution: R a. STATE pland b. COUNTY / BA  |  |
| D. CITY OR TOWN (if outside corporate limits,   c. LENGTH OF STAY IN 1b  | ,,,,   | L/I/V Talbot                                 |
| write RURAL and give nearest town)  7-5-65   | c. CITY OR TOWN (If outside corporate limits, write RURAL  | and give nearest town)                       |
| Easton   | EASTON   | 20-1   |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)   | d. STREET AOORESS  | e. IS RESIDENCE<br>ON A FARM?                |
| HOUSE IN THE PINES EASTON  | RT. 3 - BOX 95   | YES NO                                       |
| 3. NAME OF First Middle DECEASEO   | Last 4. DATE Month   | Oay Year                                     |
| Davis  |  | 12 1966                                      |
| 7. WARRIES HEVER WARRIES   | 8. OATE OF BIRTH 9. AGE (In years IFUNOER last birthday) Months  | 1 YEAR IF UNDER 24 HRS.<br>Oays Hours   Min. |
|  | [ay.4.1879   87 yrs.   |  |
| 10a. USUAL OCCUPATION (Give kind of work done 10b. KINO OF BUSINESS OR during most of working life, even if retired) INOUSTRY  | 11. BIRTHPLACE (County & State, or foreign country)   12. CC   | ITIZEN OF WHAT                               |
| Retired. Housekeeper.  | Talbot County, Md. U.  | S.A.   |
| 13. FATHER'S NAME  | 14. MOTHER'S MAIOEN NAME   |  |
| James Medford Davis.   | Mary I., Glander.  |  |
|  | INFORMANT 31 Address C   | alvert St.                                   |
| no none Wrs  |  | OTAGIO DO                                    |
| 1 18. CAUSE OF OEATH [Enter only one cause per line for (a), (b), and (c).]  | THE PARTY OF THE P | INTERVAL BETWEEN                             |
| PART I. OEATH WAS CAUSED BY:   | he woon  | ONSET ANO OEATH                              |
| 14.7.8   | -  | - 7  |
| OUE TO Conditions, If any, which \   |  |  |
| gave rise to immediate   |  |  |
| cause (a), stating the OUE TO underlying cause last.   |  | Y 1 10 1 1 1 1 1                             |
|  | TEO TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)   | 119. WAS AUTOPSY                             |
| TAC  |  | PERFORMEO?                                   |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO OEATH BUT NOT RELA  20a. ACCIOENT WAS UNDERLYING   20b. OESCRIBE HOW INJURY OCCU OR CONTRIBUTING   CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   | IRREO. (Enter nature of injury in Part I or Part II of Item 18.  | 1 4  |
| 20a. ACCIOENT WAS UNDERLYING DOR CONTRIBUTING DAY COULD OR CONTRIBUTING DAY CAUSE OF OEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  | RALO. (Little nature of injury in Part 1 of Part 11 of Item 10.  |  |
|  | CE OF INJURY (Home, farm, 1 20f. (City or town) (Cou   | inty) (State)                                |
| 20c. TIME OF INJURY Month, Oay, Year   20d. INJURY OCCURRED   20e. PLAN factor   20m.   20m | ry, street, office bldg., etc.)  | mty) (State)                                 |
| p.m. 19 at work at work  |  | _  |
| 21. I certify that (I) (this hospital) attended the deceased from  |  | hat (I) (we) last                            |
|  | death occurred at the causes and on the  |  |
| 22a. SIGNATURE   | ATTENOING MEO. STAFF 22b. 0  | ATE SIGNED                                   |
| Suppose Correct N.D  | PHYS. DIRECTOR PHYS.   |  |
| 22c. PHYSIQTAN'S<br>NAME (Type)  | 22d. AOORESS   |  |
| Stephen Carney, M. B.  | Dutchman's Lane - East   |  |
| 23a. (BURIAL) CREMATION, 23b. OATE THEREOF 23c. NAME OF CEMETERY REMOVAL (Soecify)   |  | ,  |
| UCT. 15, 1900 Spring H   | ill.   Easton, Maryla  |  |
| 24 FUNERAL DIRECTOR CAOORESS   | 25a. REC'O BY REGISTRAR 25b. REGISTRAR'  |  |
| Wellen Garley A  | DATE OCT 1 / 1966 Police   | res Juage                                    |

VR AI5 (4) 20M 1/65

77 2.1 18 Lord Tweet 5 2 10000 ses - acht c'hannetañ l  TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending by signer and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Their please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after deapth. MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

| Thomas #8 CERTIFICATE OF DEATH 14720   |  |  |  |  |  |  |  |
|--|--|--|--|--|--|--|--|
| 1. PLACE OF DEATH  |  |  |  |  |  |  |  |
| a. STATE A STATE b. COUNTY to the  |  |  |  |  |  |  |  |
| 14/00T MARYLAND 11/12/14W 0 14/158T  |  |  |  |  |  |  |  |
| b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) write RURAL and give nearest town)  |  |  |  |  |  |  |  |
| FURAL FASTON LIFE KURAL-FASTON 201   |  |  |  |  |  |  |  |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) d. STREET ADDRESS / e. IS RESIDENCE   |  |  |  |  |  |  |  |
| DIII ON A FARM?  |  |  |  |  |  |  |  |
| BELLEVUE, DOX 4 8 YES NO   |  |  |  |  |  |  |  |
| 3. NAME OF First Middle Last 4. DATE Month Day, Year   |  |  |  |  |  |  |  |
| (Type or print)  DANIE / JACKSON DEATH /0 /4 19/0/0  |  |  |  |  |  |  |  |
| 5 SEY 16 COLOR OF PACE 1   |  |  |  |  |  |  |  |
| Manufacture   1884   last birthday) Months   Days   Hours   Min.   |  |  |  |  |  |  |  |
| MAIE COIDERD WIDOWED DIVORCED CON 18584 82 yrs.  |  |  |  |  |  |  |  |
| 10a. USUAL OCCUPATION (Give kind of work done   10b. KIND OF BUSINESS OR during most of working life, even if retired)   12. CITIZEN OF WHAT COUNTRY?  |  |  |  |  |  |  |  |
| 1/54   |  |  |  |  |  |  |  |
| 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME   |  |  |  |  |  |  |  |
| 14. WHITER S WAIDER NAME   |  |  |  |  |  |  |  |
| HATHONY JACKSON EMILY GRAY   |  |  |  |  |  |  |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17. INFORMANT  (Yes, no, or unkown) [(If yes give war or dates of service)]  |  |  |  |  |  |  |  |
| 1913 00 14 P2 (1 1 P 1 100 1)  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |
| ONSET AND DEATH  |  |  |  |  |  |  |  |
| PART I. DEATH WAS CAUSED BY: My Carallel hefaulton   |  |  |  |  |  |  |  |
| 4-201  |  |  |  |  |  |  |  |
| Conditions, If any, which ) DUE TO   |  |  |  |  |  |  |  |
| gave rise to Immediate   |  |  |  |  |  |  |  |
| cause (a), stating the DUE TO  |  |  |  |  |  |  |  |
| underlying cause last. ) (c)   |  |  |  |  |  |  |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) 19. WAS AUTOPSY PERFORMED?  |  |  |  |  |  |  |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)  PERFORMED?  YES NO  OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) |  |  |  |  |  |  |  |
| 20a, ACCIDENT WAS UNDERLYING     20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)  |  |  |  |  |  |  |  |
| OR CONTRIBUTING CAUSE OF DEATH  [5] (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |
| 20c. TIME OF INJURY Month, Day, Year   20d. INJURY OCCURRED   20e. PLACE OF INJURY (Home, farm,   20f. (City or town) (County) (State)   |  |  |  |  |  |  |  |
| While   Not while  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |
| 21. I certify that (I) (this hospital) attended the deceased from 1900, that (I) (we) last   |  |  |  |  |  |  |  |
| saw the deceased alive on 18 and that death occurred at 18 M, from the causes and on the date stated above.  |  |  |  |  |  |  |  |
| 226. SIGNATURE 22b. DATE SIGNED  |  |  |  |  |  |  |  |
| M.D. ATTENDING MED. DIRECTOR DIRECTOR PHYS. DIO 18-60  |  |  |  |  |  |  |  |
| 220 PHYSICAN'S   |  |  |  |  |  |  |  |
| MAME Type, my rocker & Atmue Gael and  |  |  |  |  |  |  |  |
| 23a BURIAL CREMATION 23b DATE THEREOF   23c NAME OF CEMETERY OR CREMATORY   23d. LOCATION (City, town or county) (State)   |  |  |  |  |  |  |  |
| 23a. BURIAL, CREMATION, 23b. DATE THEREOF 23c NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City, town or county) (State)   |  |  |  |  |  |  |  |
| BURIAF 10-18-66 KICHAROS CEMETERY  |  |  |  |  |  |  |  |
| 24. FUNERAL DIRECTOR ADDRESS 25a. REC'D BY REGISTRAR'S SIGNATURE   |  |  |  |  |  |  |  |
| LADETED CIVIEN EBSTANIMA DATE OCI 24 1966 Icharles Judge   |  |  |  |  |  |  |  |
| BURGITH VIIITY FIDIOIIIII  |  |  |  |  |  |  |  |

VR AI5 (4) 20M 1/65 THE STATE OF STATE OF

The Last Cometal was a sure

3 Krall 2

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1. MARYLAND CERTIFICATE OF DEATH and 2 death. hours after death. PLACE DF DEATH USUAL RESIDENCE (Where deceased lived, If institution; Residence before admission) a. COUNTY and completely filled in by the fremove carbon papers. Pages 1 , any event, within 72 hours after A LBOT MARYLAND CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) C. LENGTH OF STAY IN 1b c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) STEVENSUILLE ST. MICHAELS filled in d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) d. STREET ADDRESS 0 executed within NAME DE 3. First Middle Last 4. DATE Month DECEASED OF OUISE LE (Type or print) DEATH Ô SEX 6. COLOR OR RACE (In years | IF UNDER 1 / EAR | IF UNDER 24 HRS. DATE OF BIRTH AGE 7. MARRIED 8. 9. NEVER MARRIED last birthday) physician and FEMALE WIDOWED DIVORCED removal, and in a 1Da. USUAL OCCUPATION (Give kind of work done) 10b, KIND OF BUSINESS OR 11. BIRTHPLACE (County & State, or foreign country) that the death certificate be during most of working life, even if retired) INDUSTRY HOUSEW!F 13. FATHER'S NAME MOTHER'S MAIDEN NAME 14. attending ph SON 0 15. WAS DECEASED EVER IN U.S. ARMED FORCES? INFORMANT ed by the attend transit permit. , cremation, or re Address 16. SOCIAL SECURITY NO. 17. (Yes, no. or unkown) (If yes give war or dates of service) 18. CAUSE OF DEATH [Enter only one cause per tine for (a), (b) and (c). been signed by the the burial-transit or to burial, cremati PART I. DEATH WAS CAUSED BY: PHYSICIAN: The law requires that the hospital or attending physician. IMMEDIATE CAUSE (a) DUE TO Conditions, If any, which (b) gave rise to immediate this certificate has been detached for use as the e Dept. of Health prior to DUE TO (a), stating underlying cause last, CERTIFICATION PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) 2Da. ACCIDENT WAS UNDERLYING IT 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of Injury In Part I or Part II of Item 18.) OR CONTRIBUTING | CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) MEDICAL TIME OF INJURY Month, Day, Year 20d. INJURY OCCURRED 20e, PLACE OF INJURY (Home, farm, 20f. (City or town) should be der ith the Str factory, street, office bldg., etc.) Hour a.m. While Not While be retained by ATTENDING at work 19 at work Tended the deceased from 21. I certify that (I) (this hospital) 19/06 director, page 3 should should be filed with the and that death occurred at 2 454M, from the causes and on the date stated above. saw the degreased alive on 22a. SIGNATIORE ATTENDING PHYS. STAFF Page 4 may k DIRECTOR M.D. PHYS. 22c. PHYSICKAN 22d. **ADDRESS** NAME (Type) Ro DATE THEREOF NAME OF CEMETERY OR CREMATORY 23a. BURIAL, CREMATION, 23b. 23c. 23d. LOCATION (City, town or county) REMOVAL (Specify) 3 FUNERAL DIRECTOR ADDRESS REC'D BY REGISTRAR 25b. 25a. 66

MARYLAND STATE DEPARTMENT OF HEALTH

VEEN

Months |

IS RESIDENCE ON A FARM?

Year

1966

NO

YES 🖂

Hours

INTERVAL BETWEEN

ONSEL

V19.

(County)

REGISTRAR'S SIGNATURE

22b.

YES

DATE SIGNED

AND DIST

WAS AUTOPSY

NO T

(State)

(State)

PERFORMED?

Day

Days

COUNTRY?

12. CITIZEN OF WHAT

VR A15 (4) 15M 4-64

14731

The same of the sa

The state of the s

the second secon

The state of the s

Andre and Ton and Ton

VR A15 (4) 20 M 1/66

4169

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

|  | Jallot  |                          | CERTIFICAT                       | TE OF DEATH                         |                                  | 14732                   |                           |  |
|--|---|--------------------------|----------------------------------|-------------------------------------|----------------------------------|-------------------------|---------------------------|--|
| 1.   | PLACE OF DEATH O. COUNTY  |                          |                                  | 2. USUAL RESIDENCE (WE              | nere deceosed lived, if institut |                         | dmission)                 |  |
|  | 1240  |                          | MARYLAND                         | MAF                                 | RYLAND b. COU                    | TALDO                   | ot                        |  |
|  | b. CITY OR TOWN (If out de corp   |                          | c. LENGTH OF STAY IN 1b          | c. CITY OR TOWN (If outs            | ide corporote limits, write RUI  | RAL ond give neorest to | wn)                       |  |
|  | casto   | W                        | 1                                | WITT                                | MAN                              | 20                      | - /                       |  |
| -  | d NAME OF HOSPITAL OR INSTITU   | JTION (If no in hospital | give street oddress)             | d. STREET ADDRESS                   |                                  | e. l.                   | S RESIDENCE<br>ON A FARM? |  |
|  | alleyar   | ial A                    | peppear                          |                                     | 394 -07 So. I                    | YES                     |                           |  |
|  | NAME OF DECEASED (Type or print)  | lace                     | U Middle                         | witeall                             | 4. DATE Mont OF LO               | h Doy                   | 19666                     |  |
| S.   | SEX 6. COLOR OF   | -                        | NEVER MARRIED                    | B. OATE OF BIRTH                    | 9. AGE (In yeors                 |                         | UNDER 24 HRS.             |  |
| 1/2  | EMALE Whi   | WIDOWEL                  | OIVORCED                         | MAR 15, 1                           | 960 66 yrs.                      | monnis odys n           | lours Min.                |  |
|  | o. USUAL OCCUPATION (Give kind of ring prost of working lite, even if ret |                          | KIND OF BUSINESS OR              | 11. BIRTHPLACE (County &            | Stote, or foreign country)       | 12. CITIZEN OF WI       | HAT                       |  |
| 1  | Seambreag!  | Shi                      | it Tractory                      | Wittme                              | en me                            | U.S                     | . (1)                     |  |
| 13. FATHER'S NAME  |   |                          |                                  |                                     |                                  |                         |                           |  |
|  | Ernest Haddaway Nettie Eogan  |                          |                                  |                                     |                                  |                         |                           |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES?  (Yes, no, or unknown) (If yes give wor or dotes of service) |   |                          |                                  |                                     |                                  |                         |                           |  |
|  | 1B. CAUSE OF DEATH (Enter or  | K                        | 12) 100                          | Jerman                              | Marshall                         | Witten                  | w                         |  |
|  |   | ONSET AND DEATH          |                                  |                                     |                                  |                         |                           |  |
| IMMEDIATE CAUSE (0)  |   |                          |                                  |                                     |                                  |                         |                           |  |
|  | Conditions, if ony, which gove ) DUE TO HEARLY LELLING (1)                |                          |                                  |                                     |                                  |                         |                           |  |
|  | rise to immediate couse (a),  |                          |                                  |                                     |                                  |                         |                           |  |
|  | stoting the underlying couse last.  | (c)                      |                                  |                                     |                                  |                         |                           |  |
|  | PART II. OTHER SIGNIFICANT CO   | NDITIONS CONTRIBUTING    | TO OEATH BUT NOT RELATED TO      | THE TERMINAL OISEASE CONDI          | TION GIVEN IN PART 1(a)          | 19. WA                  | S AUTOPSY                 |  |
| CERTIFICATION  |   |                          |                                  |                                     |                                  | PER<br>YES [            | FORMED?                   |  |
| E  | 20o. ACCIDENT WAS UNDERLYING  |                          | ). (Enter noture of injury in Po | rt I or Port II of item 1B.)        | 113                              | - 10                    |                           |  |
|  | OR CONTRIBUTING CAUSE OF O  | EATH                     |                                  |                                     |                                  |                         | ,                         |  |
| MEDICAL  | 20c. TIME OF INJURY Month, De   | - 14                     |                                  | ACE OF INJURY (Home, form,          | 20f. (City or town)              | (County)                | (Stote)                   |  |
| W.   | Hour o.m.<br>p.m.   | 19 While of wo           | e Not While of ork               | octory, street, office bldg., etc.) | 6 6                              | 07 ,                    |                           |  |
|  | 21. I certify that (I)  | (this hospital) atte     | nded the deceased fram           | 11/10/1 , 19                        | 16, to 14 010                    | 19/00 that              | (1) (we) las              |  |
|  | saw the deceased ali  | ve on                    | 14-1966 and th                   | at death accurred at 2              | M, fram causes                   | and an the date s       | tated abave               |  |
|  | 220./SIGNATURE  | 0/0/11                   | 1111                             |                                     | ED. STAFF                        | 22b. OATE SIGNEO        | 11                        |  |
|  | 28c. Physician's  | e com                    | My 1                             | A.O. PHYS. DI<br>22d. ADDRESS       | RECTOR L PHYS. L                 | 107/                    | 100                       |  |
|  | NAME (Type)   |                          |                                  | ZZG. ADDRESS                        |                                  |                         |                           |  |
| 230  | D. BURIAL, CREMATION, 23b   | . DATE THEREOF           | 23c, NAME OF CEMETERY OF         | CDEMATORY                           | 23d_LOCATION (City or Tow        | un) (faunts)            | (State)                   |  |
| 250  | REMOVAL (Specify)   | ch 18 196                | . 1/3/ //                        | reley                               | // 4 ' ' //                      | vn) (County)            | (Stote)                   |  |
| 24   | FUNERAL DIRECTOR  | 70,700                   | AODRESS                          | 250. REC'O B                        | 911                              | GISTRAR'S SIGNATURE_    | Ca /.                     |  |
| 1/0  | Flamtlelon  | , Harry                  | ami) attone                      | chall in                            |                                  | Marley Q                | udar.                     |  |

355 and the property of the contract of the contra

MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 CERTIFICATE OF DEATH 2 death. executed within 24 hours after deoth by the funeral Pages 1 and 2 PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. COUNTY b. COUNTY ofter MARYLAND c. LENGTH OF STAY IN 1b C. CITY OR LOWN b. CITY OR TOWN (If autside carparate limits, carporote limits, write RURAL and give neorest town popers. Page hin 72 hours o write RURAL and give, nearest town) Easton IS RESIDENCE ON A FARM? completely filled in d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street oddress) d. STREET ADDRESS within 72 YES | NO 7 carbon 3. NAME OF Middle Last 4. DATE Month Day Year DECEASED OF 19 DEATH any event, (Type or print) IF UNDER YFAR IF UNDER 24 HRS. SFX 6. COLOR OR RACE 7. MARRIED NEVER MARRIED DATE 9. AGE (In years remove birthday) Hours Months COLORED WIDOWED DIVORCED physicial and 10a. USUAL OCCUPATION (Give kind of work done 10b. KIND OF BUSINESS OR 12. CITIZEN OF WHAT 11. BIRTHPLACE (County & State, or foreign country) or removal, and in please COUNTR1 furing most of working life, even if retired) BORER requires that the death certificate 13. FATHER'S NAME MOTHER'S MAIDEN NAME attending phys unknows INFORMANT WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO permit. (Yes, no, or unknown) (If yes give war or dates of service) EASTON crematian, INTERVAL BETWEEN 18. CAUSE OF DEATH (Enter only one couse per ling for (a), (b), and (c).) signed by the burial-transit p ONSET AND DEATH PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) be retained by the hospital or attending physician. DUE TO burial, Conditions, if any, which gove rise to immediate cause (o), DUE TO stating the underlying couse prior to the has been last. 00 WAS AUTOPSY PERFORMED? PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH DISEASE CONDITION GIVEN IN PART 1(o) Heolth p CERTIFICATION NO TO FUNERAL DIRECTOR: After this certificate far 20o. ACCIDENT WAS UNDERLYING [ 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Port I or Port II of item 1B.) OR CONTRIBUTING CAUSE OF DEATH <del>j</del>o detached (IF EITHER, NOTIFY MEDICAL EXAMINER) Stote Dept. MEDICAL 20c. TIME OF INJURY Month, Day, Year 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Home, form, (City or tawn) (County) (Stote) Hour a.m. While Not While factory, street, office bldg., etc.) at wark at work pe 1966 to this haspital) attended the deceased fram. 21. I certify that should with the 19 6 and that death occurred at 1 a. M. from couses and an the date stated obave. saw the deceased alive on DATE SIGNED 22a. SIGNATURE 22b. DIRECTOR M.D. PHYS , poge 3 be filed 22d. ADDRESS 22c. PHYSICIAN'S 50 A 3 NAME (Type) directar, should b BURIAL, CREMATION. NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City or Town) 23b. DATE THEREOF 23 a. ADDRESS 2So. REC'D BY REGISTRAR 2Sb. REGISTRAR'S SIGNATUR FUNERAL DIRECTOR 24.

VR A15 (4) 20 M 1/66 83 6 The state of the s

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

|   |                       | 14731  |   |  | CERTI                      | IFICATE      | OF DEATH                                       |                        |                             | 1           | 473                | 1                                |                    |
|---|-----------------------|--|---|--|----------------------------|--------------|--|------------------------|-----------------------------|-------------|--------------------|----------------------------------|--------------------|
| funeral<br>1 ond<br>er deot   |                       | PLACE OF DEATH<br>D. COUNTY  | lbot  |  | MA                         | RYLAND       | 2. USUAL RESIDENCE ( o. STATE Many             | land                   | b. COU                      | NTY 7       | albox              | 2                                | 1)                 |
| and completely filled in by the funeral<br>remove carbon papers. Pages 1 ond<br>n ony event, within 72 haurs after dec  |                       | write RURAL and  |   |  | c. LENGTH OF STAY          |              | 0  | utside corporote       |                             | RAL ond giv | 2                  | 0.1                              |                    |
| ly filled in<br>oon papers.<br>within 72 h  |                       | Mem  | orial t   | to spital                              | al                         |              | d. STREET ADDRESS                              |                        |                             |             | e.<br>YE           | IS RESIDE<br>ON A FAR<br>S \ \ \ | NCE<br>RM?<br>NO 🔽 |
| carbon<br>ent, wit  |                       | NAME OF<br>DECEASED<br>(Type or print)   | 6. COLOR OR RACE  | rst V                                  | Fred                       | 1            | DATE OF BIRTH                                  | 4. DATE<br>OF<br>DEATH | Mon<br>L O<br>AGE (In years | th          | Doy                | 19 UNDER 2                       | 6<br>DAHPS         |
| ing physican and complete.<br>Then please remove car<br>removal, ond in ony event,  | n                     | ale  | white (Give kind of work done   |  | NEVER MARRI DIVORC         |              | 11/26/1887                                     | 7                      | ast sirthdoy)<br>yrs.       | Months      |                    | Hours                            | Min.               |
| scian<br>oleose<br>ond in   | duri                  | ng most of working I   | ife, even if retired)   | IN                                     | IDUSTRY                    |              | Germany  14. MOTHER'S MAIDEN                   | 4                      | gircomiy                    | (8)         | YSPY?              |                                  |                    |
| Then I  | 15.                   | Was DECEASED EVER  | F. Mielke   | 16.                                    | SOCIAL SECURITY NO.        | 17. IN       | Dona S   | . Lang                 | Addr                        | ess         |                    |                                  |                    |
| attendi<br>permit.<br>ian, or r   | (Ye                   | s, no, or unknown)   | (If yes give wor or dotes of ATH (Enter only one cou                    | of service) 27                         | 15-36-177                  | 1 5          | idney Mie                                      | lke, Ea                | ston, I                     | ld.         | 1 INTER            | VAL BETW                         | /EEN               |
| by the hospitol or ottending physicion. Iter this certificote hos been signed by the attending physician be detached for use as the burial-tronsit permit. Then please State Dept. of Health prior to burial, crematian, or removal, and in |                       | PART I. DEAT  ### O 1  Conditions, if ony, rise to immediate stating the under last.   | H WAS CAUSED BY: IMMEDIATE CAUSE  DUE which gove couse (o), lying couse | (o) Ac<br>TO Ar<br>(b) Ar<br>TO<br>(c) | teriosc                    | lerof        | nic Hea  | ur I                   | from<br>) i Se              | ne          | I PNSET            | ro                               | THV.               |
| ol or offer<br>icote hos<br>for use as<br>Heolth pri  | ICATION               |  |   |  |                            |              | IE TERMINAL DISEASE CO                         |                        |                             |             | 19. W<br>PE<br>YES | AS AUTOP<br>REORMED<br>N         | 25Y<br>0?          |
| the hospitol or<br>this certificote<br>detached for us<br>te Dept. of Heolt   | MEDICAL CERTIFICATION | OR CONTRIBUTING OF CONTRIBUTING OF CONTRIBUTING OF CONTRIBUTING OF CONTRIBUTING OF CONTRIBUTION OF CONTRIBUTIO | CAUSE OF DEATH MEDICAL EXAMINER)  |  | NJURY OCCURRED             |              | nter noture of injury in OF INJURY (Home, form |                        | (City or town)              | 160         | unty)              | /54                              | tote)              |
| d by the hos<br>After this ce<br>I be detache<br>Stote Dept.  | MEDIC                 | Hour o.m<br>p.m  | . 19  | While ot work                          | Not While of work          | foctor       | street, office bldg., etc.                     | 19 6 to                | 0 S.                        | 6           | C                  |                                  |                    |
| T < T 0   |                       | sow the de   | y that (I) (this hos  | ipi(al) offen                          | 15 19 66,                  | ond that     | eoth occurred of                               | 1 3 AM,                | from causes                 | ond on t    | he date            | stoted                           | obove              |
| AL DIREC<br>AL DIREC<br>poge 3<br>e filed w   |                       | 22c. PHYSICIAN'S<br>NAME (Type)  | Shu   | 2 cle                                  | ME                         | M.D.         | ATTENDING PHYS. 22d. ADDRESS                   | DIRECTOR L             | STAFF PHYS.                 | 10          | 10                 | ,6                               | 6                  |
| Page 4 may be retained  To FUNERAL DIRECTOR: director, page 3 should should be filed with the   | 230                   | BURIAL (REMATIO<br>REMOVAL (Specify)   | N, 23b. DATE TH   | EREOF<br>1/1966                        | 23c. NAME OF CEP<br>Spring | METERY OR SI | REMATORY                                       | 23d. 10CA              | TION (City or To            | wn)         | (County)           | (Sto                             | ite)               |
| VR A15 (4) .  | 24                    |  | ~ 1)  | 17:100                                 | ADDRESS                    | A-for        |  | D BY REGISTRAF         | 2Sb. RI                     | GISTRAR'S S |                    | dal                              |                    |

And the second of the second of the second of ward to all will during any well and any bell of the Second Second Second Service of the Servic 

RE, MARYLAND 21201

| Division of | STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMO |
|-------------|--|
| 14732       | CERTIFICATE OF DEATH   |

| 1473  | 2  |                                   | CERTIFI                       | CATE       | OF DEATH  |   | 14                | 1735  |
|---|--|-----------------------------------|-------------------------------|------------|---|---|-------------------|---|
| PLACE OF DEATH     a. COUNTY                            | TAlbot   |                                   | MARYL                         | AND        | 2. USUAL RESIDENCE (Whe c. STATE Maryla                 | 1 40.                                       | 111701            | before admission)                                 |
|   | (If autside carparate limit<br>and give nearest town)                | /                                 | LENGTH OF STAY IN             | 1b         | c. CITY OR TOWN (If outsid                              | le corporate limits, write RI<br>Rhodesdale | URAL and give r   | nearest tawn)                                     |
| d. NAME OF HOSE   | PITAL OR INSTITUTION (IF NO MENO VI al                               | at in haspital, give              |                               |            | d. STREET ADDRESS                                       |   |                   | e. IS RESIDENCE<br>ON A FARM?<br>YES NO           |
| 3. NAME OF<br>DECEASED<br>(Type or print)               |  | lara lara                         | .11                           | ughes      | Mitchella<br>S. Mitchell                                | OE  |                   | Day Year 2/ 19 6 6                                |
| S. SEX Female   | 6. COLOR OR RACE Negro   | 7. MARRIED WIDOWED                | NEVER MARRIED DIVORCED        | ₩ B.       | DATE OF BIRTH<br>an. 11, 1917                           | 9. AGE (In years                            | Manths D          | YEAR IF UNDER 24 HRS<br>Days Haurs Min.           |
| 10a. USUAL OCCUPATION of Working Most of Working Housew | ON (Give kind af wark dane<br>ng life even if retired)<br><b>OTK</b> | 10b. KIND<br>INDUS                | OF BUSINESS OR STRY Home      |            | 11. BIRTHPLACE (County & Si<br>Dorchester               | tate, ar fareign country) County, Md.       | 12. CITIZ<br>COUN | EN OF WHAT  |
| 13. FATHER'S NAME  John H                               | ughes  | Rei :                             |                               |            | 4. MOTHER'S MAIDEN NAM<br>Bertha Aldr                   |   |                   |   |
| 1S. WAS DECEASED E<br>(Yes, no. ar unknown              | VER IN U.S. ARMED FORCES?<br>) (If yes give war ar dates o           | f i M                             | -01-0515                      |            | ormant<br>dy Mitchell                                   | Add., Rhodesd                               |                   | . RFD   |
| 33  |  | (a) <u>Ce</u><br>TO (b) <u>Ce</u> | 0                             | th         | rombosi   | rosis                                       |                   | INTERVAL BETWEEN ONSET AND DEATH H days Uncertain |
| PART II. OTHER  | SIGNIFICANT CONDITIONS C   | ONTRIBUTING TO D                  | DEATH BUT NOT RELAT           | TED TO THI | TERMINAL DISEASE CONDIT                                 | 10N GIVEN IN PART 1(a)                      |                   | 19. WAS AUTOPSY PERFORMED? YES NO                 |
| OR CONTRIBUTIN  | AS UNDERLYING   AG CAUSE OF DEATH  FY MEDICAL EXAMINER)              | 20b. DESCR                        | IBE HOW INJURY OCC            | URRED. (Er | ter nature of injury in Part                            | I ar Part II af item 18.)                   |                   |   |
| 20c. TIME OF IN   | NJURY Manth, Day, Year<br>a.m.<br>p.m. 19                            | 20d. 1NJUI<br>While<br>at wark    | Nat While                     |            | OF INJURY (Hame, farm,<br>, street, affice bldg., etc.) | 20f. (City ar tawn)                         | (Caunt            | y) (State)  |
|   | tify that (1) (this hos<br>deceased olive an<br>E                    | pital) attended                   | the deceased fi               | nd that a  | , 19<br>leath accurred at                               |   | and an the        | SIGNED  |
| 22c. PHYSICIAN<br>NAME (Typ                             | l'S  |                                   |                               |            | 22d. ADDRESS_   | on, Maryland                                | 1                 |   |
| 230. BURIAL, CREMAT                                     | 4.1  |                                   | 23c. NAME OF CEMETE Petersbur |            |   | 23d. LOCATION (City or To<br>Nr. Hurlock    |                   | aunty) (State)                                    |
| 24. FUNERAL DIRECT                                      |  | Z.                                | ADDRESS .                     | 4          | 2So. REC'D BY   | REGISTRAR 2Sb. R                            | EGISTRAR'S SIGN   | VATURE  |

VR A15 (4) 20 M 1/66

TO FUNERAL DIRECTOR: After this certificate has been signed by the ottending physician and completely filled in by the funeral director, page 3 should be detoched for use os the burial-transit permit. Then please remove corbon popers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours ofter death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours ofter death. Page 4 may be retained by the hospital or ottending physician.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

4733 CERTIFICATE OF DEATH

14736

| a. COUNTY / A / ba /  | MARYLAND   |  |                                      |   |  |  |  |  |
|---|--|--|--------------------------------------|---|--|--|--|--|
| b. CITY OR TOWN (If aurside corporate limits, write RURAL and give nearest tawn)  | 39 hR.   | c. CITY OR TOWN (If outside corporate li                     | mits, write RURAL and giv            |   |  |  |  |  |
| d. NAME OF HOSPITAL OR INSTITUTION (IF not in hospit  | Hosp, Fal  | d. STREET ADDRESS  N. Main St                                | reet                                 | e. IS RESIDENCE<br>ON A FARM?<br>YES NO |  |  |  |  |
| 3. NAME OF DECEASED (Type or print) Ethel   | B rinsfield  |  | Manth 10                             | Day Year 11 19 66                       |  |  |  |  |
| S. SEX 6. COLOR OR RACE 7, MARR  Female White WIDOW   |  | 17 1006 10   | GE (In yeors IF UNDER Months 80 yrs. | Doys Haurs Min.                         |  |  |  |  |
| 10a. USUAL OCCUPATION (Give kind af wark dane during mast af working life, even if retired)  Housework  | b. KIND OF BUSINESS OR INDUSTRY Home   | 11. BIRTHPLACE (County & State, or foreign  Dorchester Count | ((                                   | TIZEN OF WHAT                           |  |  |  |  |
| 13. FATHER'S NAME William Winfield  | Brinsfield   | 14. MOTHER'S MAIDEN NAME Mary                                | Wheatley                             | <i>g</i> = 19                           |  |  |  |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, na, ar unknown) (If yes give war or dotes of service)   |  | INFORMANT  1. Sewell Morris                                  | Address<br>, Alexandri               | a, Virginia                             |  |  |  |  |
| IB. CAUSE OF DEATH (Enter only one cause per line PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)  UE TO Conditions, if any, which gove )  (b) | for (a), (b), and (c).)<br>Bronehopm<br>Annie Congri   | eumonie<br>tue hant Lauler                                   | ne                                   | INTERVAL BETWEEN ONSET AND DEATH        |  |  |  |  |
| rise ta immediate cause (o), stoting the underlying cause last. (c)  PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTII                          | NG TO DEATH BUT NOT RELATED TO   | THE TERMINAL DISEASE CONDITION GIVEN IN                      | PART I(a)                            | 19. WAS AUTOPSY                         |  |  |  |  |
| 2ernicions  | anena  | (Enter nature of injury in Part I ar Part II o               |                                      | PERFORMED? YES NO                       |  |  |  |  |
| 20c. TIME OF INJURY Manth, Day, Year Hour a.m. 20   |  | CE OF INJURY (Hame, farm, arry, street, affice bldg., etc.)  | ty or town) (Co                      | unty) (State)                           |  |  |  |  |
| saw the deceased olive on   | 21. I certify that (1) (this hospital) attended the deceased from 7 0ct , 1966, to 10 0ct , 19 6, that (1) (we) lost |  |                                      |   |  |  |  |  |
| 220. SIGNATURE Steph O Car  | mf M   |  | STAFF PHYS.                          | ate signed<br>209 66                    |  |  |  |  |
| 22c. PHYSICIAN'S Stephen P. Car   | ney M.   | D. 22d. APRESton, Maryla                                     | and Oct                              | 12, 1966                                |  |  |  |  |
| 23a. BURIAL CREMATION, REMOVAL (Specify) Burial  23b. DATE THEREOF Oct. 14, 19  |  | Feder  | ON (City or Town) alsburg, Ma        |   |  |  |  |  |
| 24 EUNERAL DIRECTOR   | And Frederild  | DATE OCT 17 1  | 986 Filian                           | iles Judge.                             |  |  |  |  |

ng and completely filled in by the funeral remove carbon popers. Poges 1 and 2 in any event, within 72 hours after death O HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours ofter death. Page 4 may be retained by the hospital or ottending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician director, page 3 should be detoched for use as the burial-transit permit. There please should be filed with the State Dept. of Health prior to burial, cremotion, or removel and

VR A15 (4) 20 M 1/66

| 14736    |                         |  | /S          |
|----------|-------------------------|--|-------------|
| on ilem? | Ano Lyzpei              |  |             |
|          | umudalarol of           |  |             |
|          | course ninti-in         |  |             |
|          |                         | Tuebanin T   |             |
|          | The sear the            |  | orine along |
|          | (b) . m(0. 19712-9800 ) | No.  | Recupation: |
|          | tand other              | Telephiante de l'  | D 0-12120   |
|          | rais ritro Mana         |  |             |
|          |                         |  |             |
|          |                         |  |             |
|          | a see waste and action  | The state of the s |             |
|          |                         |  |             |
|          |                         |  |             |
|          |                         |  |             |
|          |                         |  |             |

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH pinous 1. PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before edmission) e. COUNTY b. COUNTY hours Talbot Maryland 17 th MARYLAND and b. CITY OR TOWN (if outside corporate limits, c. LENGTH OF STAY IN 16 c. CITY OR TOWN (If outside corporate limits, write RURAL end give neerest town) write RURAL and give nearest town) affer Life Neavitt .⊆ Neavitt Pages filled d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) d. STREET ADDRESS completely papers. 3. NAME OF First Middle 4. DATE 72 DECEASED OF (Type or print) WILLIAM FRANK NEWNAM. DEATH October 14. Jr. within carbon 5. SEX 6. COLOR OR RACE 7. MARRIED TO NEVER MARRIED AGE (In years | IF UNDER 1 YEAR | IF UNDER 24 HRS. B. DATE OF BIRTH and last birthday) event Male. WIDOWED DIVORCED June 13. certificate physician remove 10e. USUAL OCCUPATION (Give kind of work 10b. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (County & State, or foreign country) done during most of working life, even if retired) any Farm Equipment Neavitt, Maryland Mechanic Then please 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME death affending William Frank Newnam Blanche Wayman 15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. | 17. INFORMANT the Address (Yes, no, or unkown) | (Ifyes give war or detes of service) requires that Mrs. Elva 217-05-3705 permit. 1B. CAUSE OF DEATH [Enter only one geuse per line for (e), (b), end (c).] physician. þ 5 PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (e) signed cremation, burial-transit DUE TO attending Conditions, if eny, which peen geve rise to immediate couse (a), steting the underlying burial, has the ō PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NO certificate CERTIFICATION the hospital 8 0 prior for use 20b. DESCRIBE HOW INJURY OCCURRED. (Enter neture of injury in Part I or Part II of item 1B.) 20a. ACCIDENT WAS UNDERLYING IT OR CONTRIBUTING | CAUSE OF DEATH DIRECTOR: After this of Health (IF EITHER, NOTIFY MEDICAL EXAMINER) detached MEDICAL be retained by 20e. TIME OF INJURY 20d. INJURY OCCURRED | 20e. PLACE OF INJURY (Home, ferm, ! Month, Dey, Yeer 20f. (City or town) fectory, street, office bldg., etc.) Hour a.m. While Not While at work at work D.M. P 21. I certify that (I) (this hospital) attended the deceased from. plnous State ......1940..., and that death occurred saw the deceased alive on SIGNATURE ATTENDING DIRECTOR PHYS. PHYS. M.D. FUNERAL rector, page filed with the 22c. PHYSICIAN'S 22d. ADDRESS Page NAME (Type) GUY M. REESER Jr. . D. St. Michaels, Maryland M. 23e. BURIAL, CREMATION, 23b. DATE THEREOF 23c. NAME OF CEMETERY OR CREMATORY REMOVAL (Specify) 9:0 Neavitt Cemetery Buria1 Oct 17, 1966 24 FUNERAL DIRECTOR'S SIGNATURE ADDRESS

Newnam, Neavitt, Marvland INTERVAL BETWEEN ONDET AND DEATH RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(e) 19. WAS AUTOPSY PERFORMED? NO Y (County) (Stete) D.M. from the causes and on the date stated above. 22b. DATE SIGNED 23d. LOCATION (City, town or county) Neavitt, Maryland 25e. REC'D BY REGISTRAR 25b. REGISTRAR'S SIGNATURE

Talbot

e. IS RESIDENCE ON A FARM? YES NO

> 66 19

Year

12. CITIZEN OF WHAT COUNTRY?

USA

VR A1S (4)

|            | bastyrass  |                    | doctor  |       |
|------------|--|--------------------|---------|-------|
|            | and the same of  |                    | 11Wast  |       |
|            | The Control of the Co |                    | en prod | VOL.  |
| (FA TEMPS) |  | MARK TRAIN N       |         |       |
|            | June 13, 1911 15   |                    | otkilli | 21-04 |
|            | onskytok ritizak   | Intercence lizare. | 01      |       |

THE CONTRACT OF THE PROPERTY O

LOTE CONTROL TO THE SECOND SELS, MARYSLAND -

urtal oct 17, 1966 Scartil confirmy masket, marking

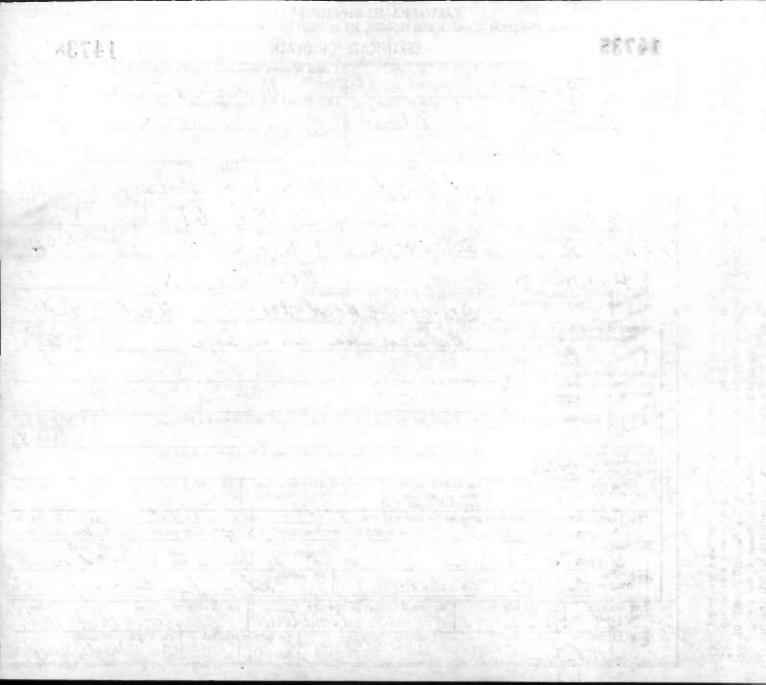
MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 4735 14738 CERTIFICATE OF DEATH

| _             |  |                                      |   |   | 2 - 4 - 4                         |  |  |
|---------------|--|--------------------------------------|---|---|-----------------------------------|--|--|
| 1.            | a. COUNTY  | MARYLAND                             | 2. USUAL RESIDENCE (Where o. STATE                        | deceosed lived, if institution: Residence | dence before odmission)           |  |  |
| -             | b. CITY OR TOWN (If outside corporate limits,  | c. LENGTH OF STAY IN 1b              | c. CITY OR TOWN (If outside                               | corporate limits, write RURAL and         | give neorest town)                |  |  |
|               | write RURAL and give nearest town)   | 8days                                | C   | DESTER                                    | 17.2                              |  |  |
|               | d. NAME OF HOSPITAL OR INSTITUTION (If not in  | nospitol, give street oddress)       | d. STREET ADDRESS   |   | e. IS RESIDENCE<br>ON A FARM?     |  |  |
|               | memorial +   | tospital                             |   |   | YES NO                            |  |  |
| 3.            | NAME OF OECEASED   | hol FMIIV                            | 201-0   | DATE Month OF DEATH Octobee               | Doy Year 15 19 66                 |  |  |
| S.            | (Type or print)  SEX  6. (OLOR OR RACE 7. I  | MARRIED A NEVER MARKIED E            | B. DATE OF BIRTH  | 9. AGE (In years   IF UNDI                | R I YEAR IF UNDER 24 HRS.         |  |  |
|               | Female Negro W   | IDOWED DIVORCED                      | TUN. 7, 1905  | last birthdoy) Months                     | Doys Hours Min.                   |  |  |
| de            | to USUAL OCCUPATION (Give kind of work done printing most of working life, even if retired)  | DOWN ESTIC                           | 11. BIRTHPLACE (County & Stot                             |   | COUNTRY 2/5A                      |  |  |
|               | 3. FATHER'S NAME   |                                      | 14. MOTHER'S MAIDEN NAME                                  | 6   |                                   |  |  |
|               | UNKNOWN  |                                      | MARY G  | REEN                                      |                                   |  |  |
|               | S. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(es, no, or unknown) (If yes give wor or dotes of sen  |                                      | aspli fee   | Address & axte                            | in God'                           |  |  |
|               | 1B. CAUSE OF DEATH (Enter only one couse pe<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (o)   | r line for (o), (b), and (c).)       | il keur au  | leage                                     | INTERVAL BETWEEN ONS T AND OFATH  |  |  |
|               | 330 × DUE TO   |                                      |   |   |                                   |  |  |
|               | Conditions, if ony, which gove (b)   |                                      |   |   |                                   |  |  |
|               | stoting the underlying couse (c) DUE TO  |                                      |   |   |                                   |  |  |
| ATION         | PART II. OTHER SIGNIFICANT CONDITIONS CONTR  | BUTING TO DEATH BUT NOT RELATED TO T | HE TERMINAL DISEASE CONDITIO                              | ON GIVEN IN PART 1(0)                     | 19. WAS AUTOPSY PERFORMED? YES NO |  |  |
| CERTIFICATION | I (II LITTLE, NOTH I MEDICAL LAAMINEA)   | 205. DESCRIBE HOW INJURY OCCURRED. ( | Enter noture of injury in Port I                          | or Port II of item 1B.)                   |                                   |  |  |
| MEDICAL       | 20c. TIME OF INJURY Month, Day, Yeor<br>Hour o.m.<br>p.m. 19   |                                      | E OF INJURY (Home, form, ory, street, office bldg., etc.) |   | County) (Stote)                   |  |  |
|               | 21. 1 certify that (I) (this haspital) attended the deceased fram 2024, 1966, to 1504, 1966 that (I) (we) last saw the deceased alive on 1404 1966 and that death occurred at 810 M, fram causes and an the date stated above. |                                      |   |   |                                   |  |  |
|               | 220. SIGNATURE M.O. ATTENDING MED. STAFF 22b. DATE SIGNED  17 Del 44   |                                      |   |   |                                   |  |  |
|               | 22c. PHYSICIAN'S<br>NAME (Type) + HU17 STON  | TARRISON                             | 22d. ADDRESS Carta  | in thoughours                             |                                   |  |  |
| 2:            | BO. BURIAL, CREMATION, REMOVAL (Specify) 23b. OATE THEREOF   | 23c. NAME OF CEMETERY OR C           | Cemetery 2  | 3d. LOCATION (City or Town)               | (County) (Stote)                  |  |  |
|               | 24. FUNERAL DIRECTOR   | Lashings 5 Flis                      | DATE OCT  |   | SIGNATURE Quesas                  |  |  |

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and campletely filled in by the funeral director, page 3 should be detached far use as the burial-transit permit. The place remave carban papers. Pages 1 and 2 should be filed with the State Dept. af Health priar ta burial, crematian, or remaval, and in any event, within 72 haurs after death TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 haurs after death. Page 4 may be retained by the haspital ar attending physician.

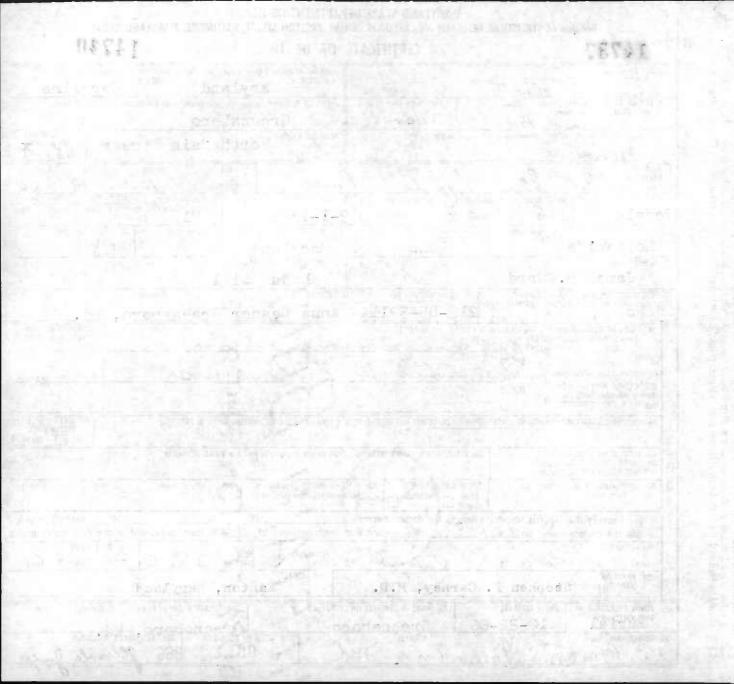
VR A15 (4) 20 M 1/66



MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH funeral and 2 death. and PLACE OF DEATH USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) the 1. a. COUNTY b. COUNTY Talbox Talbat Pages 1 urs after MARYLAND CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) c. LENGTH OF STAY IN 1b within 72 hours hours ean .= Irappe d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) filled d. STREET ADDRESS e. IS RESIDENCE ON A FARM? Main Street Main Street NO 7 YES completely carbon NAME OF Middle DATE Month Year DECEASED Outten. Sr. 1966 Benjamin Franklin event. (Type or print) DEATH DATE OF BIRTH AGE (In years | IF UNDER 1 YEAR | IF UNDER 24 HRS remove 7. MARRIED NEVER MARRIED last birthday) and male WIDOWED DIVORCED = 10a. USUAL OCCUPATION (Give kind of workdone | 10b. KIND OF BUSINESS OR 11. BIRTHPLACE (County & State, or foreign country) 12. CITIZEN OF WHAT during most of working life, even if retired) INDUSTRY physicia en pleas 1-armina death certificate 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME he attending phy permit. Then p tion, or temoval, William H. Outten 15. WAS DECEASED EVER IN U.S. ARMED FORCES? 17. INFORMANT Address (Yes, no, or unkown) (If yes give war or dates of service) ned by the att Il-transit perm Il, cremation, o Mrs. Outten. no 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c). INTERVAL BETWEEN ONSET AND DEATH PART I. DEATH WAS CAUSED BY: attending physician. IMMEDIATE CAUSE (a) signed instantial the purial, the burial, the burial the buri **DUE TO** heros aluone Cenditions, If any, which (b) gave rise to immediate DUE TO (a), stating as th underlying cause last. CERTIFICATION PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) WAS AUTOPSY for use Health PERFORMED? certificate the hospital or YES NO [ PHYSICIAN: 20a. ACCIDENT WAS UNDERLYING DESCRIBE HOW INJURY OCCURRED. (Enter nature of Injury in Part I or Part II of Item 18.) t, of OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) ach MEDICAL 20c. TIME OF INJURY Month, Day, Year 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Home, farm, 20f. (City or town) (State) (County) det be de State factory, street, office bldg., etc.) Hour a.m. After Id be d While Not While at work at work retained 58 1966 that (i) (we) last 21. I certify that (i) (this hospital) attended the deceased from DIRECTOR: Jage 3 should lied with the C. M. from the causes and on the date stated above. saw the deceased alive on and that death occurred at. 22a. SIGNATURE 22b. DATE SIGNED page 06/46 ATTENDING MED. STAFF M.D. PHYS. DIRECTOR PHYS. 4 may Page 4 may FUNERAL PHYSICIAN'S 22d. ADDRESS director, p BURIAL, CREMATION, 23b. DATE THEREOF 23c. NAME OF CEMETERY OR CREMATORY LOCATION (City, town or county) (State) 0 REMOVAL (Specify) aston. Durial 25b. REGISTRAR'S SIGNATURE caston. Ad. VR AI5 (4) 20M 1/65

1, 1, reference and the 7 \_ t \_ t \_ t \_ t \_ max \_ max

MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 CERTIFICATE OF DEATH requires that the death certificate be executed within 24 hours ofter death completely filled in by the funeral nove carbon papers. Pages 1 and 3, y event, within 72 hours ofter death 1. PLACE OF DEATH 2. USUAL RESIDENCE (Where deceosed lived, if institution: Residence before admission) a COUNTY b. COUNTY Maryland Caroline MARYLAND b. CITY OR TOWN (If outside corparate limits C. LENGTH OF STAY IN 1b c. CITY OR TOWN (If outside corparate limits, write RURAL and give neorest town) write RURAL and give negrest town 3 days Greensboro aston d. STREET ADDRESS IS RESIDENCE d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street oddress) North Main Street ON A FARMS Mercovial NO" 3. NAME OF First Middle 4. DATE Month Day Year DECEASED 0F ilyder 10 (Type or print) DEATH 19 SEX DATE OF BIRTH IF UNDER 1 YEAR IF UNDER 24 HRS 6. COLOR OR RACE 7. MARRIED NEVER MARRIED AGE (In years remove birthday) Months Days Hours ast Female any White X WIDOWED DIVORCED ond 10a. USUAL OCCUPATION (Give kind of work done 10b. KIND OF BUSINESS OR 12. CITIZEN OF WHAT 11. BIRTHPLACE (County & State, or foreign country) = during most of working life even if retired) INDUSTRY COUNTRY? ondi pleose physician None Maryland 14. MOTHER'S MAIDEN NAME 13. FATHER'S NAME or removal, en James H. Ward Dill Rhoda signed by the attending burial-transit permit. Th INFORMANT 15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17. Address (Yes, no not unknown) (If yes give wor or dates of service Deaner Anna Greensboro. cremation, CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). INTERVAL BETWEEN ONSET AND DEATH PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) attending physician. DUE TO buriol, a Conditions, if any, which gave rise to immediate cause (a), DUE TO stating the underlying cause prior to hos been last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) WAS AUTOPSY PERFORMED? use CERTIFICATION Heolth NO TO FUNERAL DIRECTOR: After this certificate be retoined by the hospitol or far 205. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20g. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH of detoched (IF EITHER, NOTIFY MEDICAL EXAMINER) MEDICAL 20e. PLACE OF INJURY (Home, form, 20c. TIME OF INJURY Month, Day, Year 20d INJURY OCCURRED (City or tawn) (County) (Stote) Haur a.m. While Not While factory, street, office bldg., etc.) Stote | at work at work Pe 21. I certify that (1) (this hospital) attended the deceosed from 19\_\_\_\_, that (i) (we) last ta director, page 3 should should be filed with the 19 6 6, and that deoth occurred of 5 32M, fram causes and on the date stated above. saw the deceased alive an / 22a. SIGNATURE 22b. DATE SIGNED MED. **ATTENDING** STAFF 200 M.D. DIRECTOR PHYS. PHYS 22d. ADDRESS 22c. PHYSICIAN'S NAME (Type) Stephen P. Carney, M.D. Easton, Maryland 23a. BURIAL, CREMATION, 23b. DATE THEREOF 23c. NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City or Town) (Stote) (County) 10-22-66 Greensboro Greenshara 25h REGISTRAR'S SIGNATURE 25g. REC'D BY REGISTRAR 24:1 FUNERAL DIRECTOR ADDRESS VR A15 (4) 20 M 1/66



# FOR STATE HEALTH DEPT please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death. y is necessary,

EDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any

IO DEPUTY

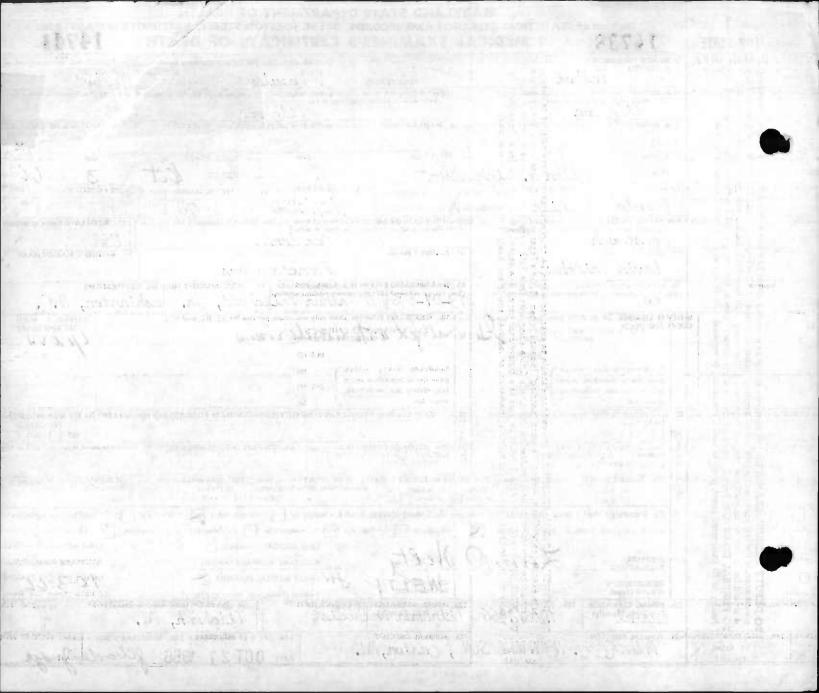
## MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

| 14738 MEDICAL EXAMINER'S  | S CERTIFICATE OF DEATH   | 14741   |
|---|--|---|
| 1. PLACE OF DEATH  a. COUNTY  | 2. USUAL RESIDENCE (Where deceased lived, If instit                            | ution: Rasidenca before admissio                  |
| Talbot MARYLAND   | e. STATE b. COUNTY   | Talbot  |
| b. CITY OR TOWN (if outside corporete limits, e. LENGTH OF STAY IN 16   | c. CITY OR TOWN (If outside corporate limits, write RUI                        | RAL end give neerest town)                        |
| write_RURAL and give nearest lown)  | Tilohman   | ** (  |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospitel, give street address)  | d. STREET ADDRESS  | 1 a. IS RESIDENC                                  |
|   |  | ON A FARM   |
| 3. NAME OF First Middle   | Last 4. DATE Month   | Day Year  |
| (Type or print) Ellen A. Richardson   | OF DEATH   | 3 1966  |
|   | DATE OF BIRTH 9. AGE (In years   IF U  |   |
|   | 0/20/4000 last birthday) Mo  | nihs Days Hours Min.                              |
|   | 9/2//1000 /O yrs.  |   |
| Da. USUAL OCCUPATION (Give kind of work long, during most of working life, even if retired)   | Y 11. BIRTHPLACE (State or foreign country)                                    | 12. CITIZEN OF WHAT COUNTRY                       |
| Housework   | Maryland   | USA   |
| 3. FATHER'S NAME  | 14. MOTHER'S MAIDEN NAME   |   |
| Levin Pritchett   | Frances Adams  |   |
| 18. CAUSE OF DEATH   Enter only one cause par line for (a), (b), and (c).)  PART I. DEATH WAS CAUSED BY:                            | Anthur Pritchett, In. Washi<br>rios clerosis                                   | INTERVAL BETWEEN ONSET AND DEATH                  |
| IMMEDIATE CAUSE (a)   | the vote to disky  | years   |
| 45 0 DUE TO   |  | /   |
| Conditions, if any, which (b)   |  |   |
| (a), stating the underlying DUE TO  |  |   |
| cause last. (c)   |  |   |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NO  200. EXTERNAL CAUSE WAS PRIMARY OF CONTRIBUTING CAUSE OF DEATH. | T RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IF                           | PART I(a) 19. WAS AUTOPSY<br>PERFORMED?<br>YES NO |
| 20%. EXTERNAL CAUSE WAS PRIMARY   or CONTRIBUTING   CAUSE OF DEATH.  20b. DESCRIBE HOW INJURY OCCURRED.                             | (Entar nature of injury in Pert I or Pert II of item 18.)                      |   |
|   | CE OF INJURY (Home, farm, 20f. (City or town) ory, street, office bldg., etc.) | (County) (Stata)                                  |
| 21. I certify that I took charge of the remains described above, hel  | d an Autopsy . Inspection Inquiry  | , and in my opinion                               |
| death resulted from: Natural causes Accident . Suici  | de . Homicide . Undetermined manne   | er 🗍  |
| 0 0 1   | CHIEF MEDICAL EXAMINER   |   |
| ACTUAL LOWIS . Welty  | ASSISTANT MEDICAL EXAMINER   | DATE SIGNED                                       |
| EXAMINER'S NAME (Type)  | Address (Street, city, town, or county)  | 10-3-66   |
| 28. BURIAL, CREMATION, 226. DATE THEREOF 226. HAME OF CEMETERY OR DISTRIBUTION 10/6/1966 lighman Method                             |  | county) (State)                                   |
| 23. FUNERAL DIRECTOR ADDRESS  | 24s. REC'D BY REGISTRAR   24b. REGISTRA  | AR'S SIGNATURE                                    |

VR AISME 5M 1/63

MAURICE E. NEWNAM & SON, Easton, Md.

1966



MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 4739 CERTIFICATE OF DEATH ond death. requires that the death certificate be executed within 24 hours after death completely filled in by the funeral ove carbon papers. Pages 1 and PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. COUNTY b. COLINTY MARYLAND b. CITY OR TOWN (If outside carparate limits c. LENGTH OF STAY IN 1b limits, write RURAL and give negrest town) write RURAL and give negrest town) RAL EASTON d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) d. STREET ADDRESS e. IS RESIDENCE ON A FARM? ve carbon papers. event, within 72 h YES 🗌 NO 3. NAME OF Middle 4. DATE Manth Year DECEASED 0F 19 6 (Type ar print) DEATH S SEX AGE (In years IF UNDER 1 YEAR IF UNDER 24 HRS. 6. COLOR OR RACE 7. MARRIED NEVER MARRIED DATE OF BIRTH last birthdoy) Months Days Hours WIDOWED DIVORCED 22 10a, USUAL OCCUPATION (Give kind of work done 10b. KIND OF BUSINESS OR 12. CITIZEN OF WHAT BIRTHPLACE (County & State, or foreign country) during most of warking life, even if retired) **INDUSTRY** COUNTRY? 1.1501 NEA physicion pleci 13. FATHER'S NAME MOTHER'S MAIDEN NAME. 14. removol, WAS DECEASED EVER IN U.S. ARMED FORCES? 17 INFORMANT 16 SOCIAL SECURITY NO (Yes, na or unknawn) (If yes give war or dates af service 0 cremotion, INTERVAL BETWEEN AB. CAUSE OF DEATH (Enter only one cause per line for (a), signed by the buriol-transit PART I. DEATH WAS CAUSED BY ONSET AND DEATH IMMEDIATE CAUSE (o) DUE TO Canditians, if ony, which gave rise to immediate cause (a). DUE TO attending p stoting the underlying cause as the prior to TO FUNERAL DIRECTOR: After this certificate hos been last. 19. WAS AUTOPSY PERFORMED? PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) YES [ NO the hospitol or 20g. ACCIDENT WAS UNDERLYING 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.) OR CONTRIBUTING CAUSE OF DEATH of detached (IF EITHER, NOTIFY MEDICAL EXAMINER) 20c. TIME OF INJURY Manth, Day, Year 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Hame, farm, (City or town) (County) (State) Hour a.m. Not While factory, street, affice bldg., etc.) at work at wark þ 21. I certify that (1) (this hospital) attended the deceased from to 19\_\_\_\_, that (1) (we) last be retoined plnous and that death accurred at 5 2 km, fram causes and an the date stated above. saw the deceased alive an 22a. SIGNATURE 22b. DATE SIGNED Robert W. Trever ATTENDING STAFF M.D. DIRECTOR 22d. ADDRESS 22c. PHYSICIAN'S NAME (Type) director, should 230 BURIAL CREMATION 23b. DATE THEREOF 23c. NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City or Town) (County) (State) REMOVAL (Specify) 24. FUNERAL DIRECTOR 2Sa. REC'D BY REGISTRAR 2Sb. REGISTRAR'S SIGNATURE VR A15 (4) 20 M 1/66

18.00 14742 The Control of the Co

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14740

# CERTIFICATE OF DEATH

14743

|    |               | PLACE OF DEATH   | 2. USUAL RESIDENCE (Where deceased lived, if institution: Reside   | nce befare admission)                   |  |
|----|---------------|--|--|---|--|
|    |               | a. COUNTY / All of MARYLAND  | a. STATE Maryland b. COUNTY Talbot   |   |  |
|    |               | b. CITY OR TOWN (If autyde corporate limits, c. LENGTH OF STAY IN 1b write. RURAL and give nearest town)   | c. CITY OR TOWN (If outside carparate limits, write RURAL and giv  | ve nearest town)                        |  |
|    | -70           | Eastown Valadus  | Easton   | 20.1                                    |  |
| 00 | J             | d HAME OF HOSPITAL OR INSTITUTION (If not in hospital, live street address)  | d. STREET ADDRESS  | e. IS RESIDENCE<br>ON A FARM?           |  |
| 78 |               | alluraria Hospilas   | 347 N. Washington St.  | YES NO                                  |  |
|    |               | NAME OF PITST Middle   | Last 4. DATE Manth   | Day Year                                |  |
|    |               | (Type or print) CUCA DRUTOUS   | MULLED DEATH OC  | 17 1960                                 |  |
|    | S. :          |  | 8. DATE OF BIRTH 9. AGE (In years IF UNDER last birthday) Months   | 1 YEAR IF UNDER 24 HRS. Days Hours Min. |  |
|    |               | MIDONED DITOREED   | Aug. 25, 1938 28 yrs.  |   |  |
|    |               | . USUAL OCCUPATION (Give kind af wark done ing most of warking life, even if retired) /// // // // // // // // // // // // /   |  | TIZEN OF WHAT                           |  |
|    |               | Printer war roug riess   | The state of the s | ISA                                     |  |
|    | 13.           | FATHER'S NAME  | 14. MOTHER'S MAIDEN NAM heresa   |   |  |
|    | 15            | David B. Skinner, Sr.  | AKERESEXXERESE Kohn  |   |  |
|    | (Ye           | se no gruph nave) ((fuer site was as dates of contice)   | NFORMANT Address   | A1 1-3                                  |  |
| 10 |               |  | rs. David B. Skinner, Easton,  |   |  |
| 70 |               | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY:   |  | INTERVAL BETWEEN ONSET AND DEATH        |  |
|    |               | IMMEDIATE CAUSE (a) Hoagens a  | uncent.  |   |  |
| 2  |               | Conditions, if ony, which gove ) (b)   |  | dain                                    |  |
|    | 0             | rise to immediate cause (a),   |  |   |  |
|    |               | stating the underlying cause (c)   |  |   |  |
|    | _             | PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO   | THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)  | 19. WAS AUTOPSY                         |  |
| 0  | CERTIFICATION |  |  | PERFORMED? YES NO                       |  |
|    | JE C          |  | (Enter nature of injury in Part I or Port II of item 18.)  |   |  |
| 3  |               | OR CONTRIBUTING 🗆 CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |   |  |
|    | MEDICAL       |  |  | unty) (State)                           |  |
|    | ME            | Haur a.m. While Not While of work of the standard of the stand | ary, street, affice bldg., etc.)   |   |  |
|    |               | 21. I certify that (I) (this haspital) attended the deceased fram_   | , 19, ta, 19   | , that (I) (we) las                     |  |
| 10 |               |  | t death accurred at as M, from causes and on t   |   |  |
| 12 |               | 22a. SIGNATURE   | ATTENDING MED. STAFF   | ATE SIGNED                              |  |
|    | -             | Robert W. Trever M.  | D. PHYS.   |   |  |
| 1  |               | 22c. PHYSICIAN'S<br>NAME (Type) Robert W. Trevon   | Easton, Nd.  |   |  |
|    | 230           | BURIAL, CREMATION, 23b. DATE THEREOF 23c. NAME OF CEMETERY OR  |  | (County) (Stote)                        |  |
|    |               | REMOVAL Specific 10/20/1966 (hesterfield   |  |   |  |
| 9  | 24.           | FUNERAL DIRECTOR ADDRESS   | 250. REC'D BY REGISTRAR 25b. REGISTRAR'S S   | IGNATURE) udge                          |  |
| 1  | 11            | lawie to New Harmanon ( hoton), 1  | Md. DATE OCI 19 1966 7000  | 00                                      |  |

TO FUNERAL DIRECTOR: After this certificate has been signed by the ottending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and any event, within 72 hours ofter death. **TO HOSPITAL OR ATTENDING PHYSICIAN:** The low requires that the deoth certificate be executed within 24 hours after death Page 4 may be retained by the hospital or attending physician.

VR A15 (4) 20 M 1/66

And Demonstrate . The state of the state of

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH funeral and 2, death. and 2 death. PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. COUNTY Maryland b. CDUNTY by the f Pages 1 urs after Caroline MARYLAND b. CITY OR TOWN (if outside corporate limits, c. LENGTH DF STAY IN 1b c. CITY DR TDWN (If outside corporate limits, write RURAL and give nearest town) hours write RURAL and give nearest town) Goldsboro filled In as ON papers. d. NAME DF HDSPITAL DR INSTITUTION (if not in hospital, give street address) d. STREET ADDRESS e. IS RESIDENCE DN A FARM? within 72 None Morial NO -YES and completely remove carbon NAME OF **First** Middla Last 4. DATE Month Day Year DECEASED event, (Type or print) DEATH 0 19 6 5. SEX 6. COLOR OR RACE DATE OF BIRTH AGE (In years | IF UNDER 1 YEAR | IF UNDER 24 HRS NEVER MARRIED last birthday) Months I Days Hours any and White Male -24-1894 WIDDWED DIVDRCED = 10a. USUAL DCCUPATION (Give kind of workdone | 10b. KIND OF BUSINESS OR 12. CITIZEN DF WHAT sician Slease r 11. BIRT HPLACE (County & State, or foreign country) CDUNTRY? during most of working life, even if retired) INDUSTRY and Retired Farmer Marvland certificate 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME remova Gouldsborough Smith Susie Laramore been signed by the attendi the burial-transit permit. It to burial, cremation, or re 15. WAS DECEASED EVER IN U.S. ARMED FDRCES? 16. SDCIAL SECURITY ND. 17. INFORMANT Address (Yes, no, or unkown) (If yes give war or dates of service) death lson Smith Goldsboro Maryland 18. CAUSE DF DEATH [Enter only one cause per\_line for (a), (b), and (c). INTERVAL BETWEEN requires that the DNSET AND DEATH PART I. DEATH WAS CAUSED BY: attending physician. 12 ano IMMEDIATE CAUSE (a) DUE TD Conditions, if any, which (b) gave rise to immediate DUE TD cause (a), stating the prior underlying cause last. has SB NO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) 19. WAS AUTOPSY for use Health PERFORMED? DIRECTOR: After this certificate ge 3 should be detached for use led with the State Dept. of Health CERTIFICATI YES NO V 20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE DF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY DCCURRED. (Enter nature of injury in Part i or Part ii of Item 18.) MEDICAL 20c. TIME OF INJURY Month, Day, Year 20d. INJURY DCCURRED 20e. PLACE DF INJURY (Home, farm, 20f. (City or town) (County) (State) factory, street, office bidg., etc.) Hour a.m. Not While While OR ATTENDING F at work at work 21. I certify that (I) (this hospital) attended the deceased from 5 0ct 1966 tn and that death occurred at 30 M. from the causes and on the date stated above. saw the deceased alive on. 22a. SIGNATURE 22b. DATE SIGNED PHYS. page STAFF M.D. DIRECTOR 4 may PHYSICIAN'S Stephen TO FUNERAL 22d. ADDRESS Carnev director, p Maryland East on. BURIAL, CREMATION, 23b. DATE THEREOF 23c. NAME OF CEMETERY DR CREMATORY LOCATION (City, town or county) 23a. (State) REMOVAL (Specify) Greensboro Maryland Greensboro REC'D BY REGISTRAR | 25b. REGISTRAR'S SIGNATURE FUNERAL DIRECTOR ADDRESS VR A.15 (4) 20M

williams Similaria " The AC C TOWN THE PROPERTY OF THE PARTY OF THE P The Tayl A. A. -- A removal creda novel 1. Da-1-

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

| 1919% CERTIFICAT   | L OF DEATH  |
|--|---|
| 1. PLACE OF DEATH a. COUNTY DOT  MARYLAND  | 2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission a. STATE yland b. COUNTFalbot  |
| b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)  Easton  c. LENGTH OF STAY IN 1b  From 7-6-66   | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)  Rural-Trappe  201   |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) HOUSE IN THE PINES EASTON   | d. STREET ADDRESS  RT. 3 - BOX 95  e. IS RESIDENCE ON A FARM? YES \( \sum \) NO (2)   |
| 3. NAME OF First Middle DECEASED (Type or print) Ethel Robinson  | Spicer   4. DATE   Month   Oay   Year   DF   DEATH   10   10   19   66  |
|  | 8. DATE OF BIRTH April 10, 1904  9. AGE (In years   IFUNDER 1 YEAR   IF UNDER 24 HRS   April 10, 1904  9. AGE (In years   IFUNDER 1 YEAR   IF UNDER 24 HRS   Months   Oays   Hours   Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWLIE HOME   | Dorchester Co., Maryland 12. CITIZEN OF WHAT COUNTRY? USA   |
| Joseph L. Robinson   | 14. MOTHER'S MAIDEN NAME Alexina Navy   |
|  | s. Arthur Fehsenfeld, RFD, Trappe, Md.  |
| PART I. OEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)  OUE TO Conditions, If any, which gave rise to immediate cause (a), stating the underlying cause last.  OUE TO (b) DUE TO (c) | and Athers solers tic The Disease TRS.  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELA  20a. ACCIDENT WAS UNDERLYING  OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)    | PERFORMED? YES NO NO  |
|  | JRREO. (Enter nature of injury in Part I or Part II of Item 18.)  |
|  | CE OF INJURY (Home, farm, 20f. (City or town) (County) (State) ry, street, office bldg., etc.)  |
| 21. I certify that (I) (this hospital) attended the deceased from saw the deceased alive on 1900, and that 22a. SIGNATURE  | t death occurred at M, from the causes and on the date stated above.  ATTENDING MED. DIRECTOR STAFF LO. (0.66)  |
| 22c. PHYSICIAN'S NAME (Type) Dr. Sheperd Krech   | Talbottown Lane - Easton, Md.   |
| 23a. BURIAL, CREMATION, 23b. DATE THEREOF 23c. NAME OF CEMETERY BURIAL (Specify) Oct 12 1966   Dorchester Mo   |   |
| 24. FUNERAL OIRECTOR ADDRESS   | MJ 25a. REC'D BY REGISTRAR 25b. REGISTRAR'S SIGNATURE   |

VR AI5 (4) 20M 1/65

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, of removal, and in any event, within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

3 de la francisco eg rui-Lenn de-e-raga 20 SLE - E ON HE A art 10, 19th 50 And the second s Real Carlon Land of Call adding and produced with down to poor will yell to be a second and the state of the state of the state of .b. , -- we - one i swedtoclat conditioned to the urilly on 12 1500 ker bound with a set of medical control of the The state of the s

# 2, anu p. PM3. Page Department of delay

72 haurs

within

event

any

=

and File

remaval,

ь

crematian,

burial,

its designated agent, priar

Health or

CERTIFICATION

MEDICAL

Hour o.m.

burial-transit

0

pe ţ

shauld

State [

Office alang with farm

Examiner

24 haurs after death.

within

This certificate shauld be executed

ecute the certificate, writing the ward "pending" in Page 4 shauld be farwarded ta the Chief Medical

Item |

a. COUNTY

3. NAME OF

DECEASED

MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) PLACE OF DEATH b. COUNTY MARYLAND b. CITY OR TOWN (If outside corporate limits, c. LENGTH OF STAY IN 1b. outside corporate limits, write RURAL and give nearest town) write RURAL and give negrest town) 18EN QUEEN ANNE d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) d. STREET ADDRESS e. IS RESIDENCE ON A FARM? NO I Middle First Lost 4. DATE Month Doy Year (Type or print) IF UNDER 1 YEAR IF UNDER 24 HRS 6. COLOR OR RACE 7. MARRIED NEVER MARRIED AGE (In years t hirthday) **NEGRO** Days DIVORCED DEC: 11 WIDOWED 10o. USUAL OCCUPATION (Give kind of work done IDb. KIND OF BUSINESS OR 12. CITIZEN OF WHAT during most of working life, even if retired) INDUSTRY COUNTRY 13. FATHER'S NAME 14. MOTHER'S MAIDEN MILLER 15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO 17 INFORMANT Address (Yes, no, or unknown) (If yes give war or dates of service) QUEEN ANNE, MO. INTERVAL BETWEEN 18. CAUSE OF DEATH (Enter only one couse per line for (a), (b), and (c),) PART I. DEATH WAS CAUSED BY ONSET AND DEATH MYOCARDIAL FAILURE IMMEDIATE CAUSE (o) DUE TO YEARS CHRONIC MYOCARDITIS Conditions, if ony, which gove

foctory, street, office bldg., etc.)

rise to immediate couse (a). DUE TO stoting the underlying couse PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) 2Do. EXTERNAL CAUSE WAS 2Db. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port II of item 18.)

PRIMARY CONTRIBUTING CONTRIBUTING CAUSE OF DEATH. 2Dc. TIME OF INJURY Month, Day, Year 2Dd INJURY OCCURRED 2De. PLACE OF INJURY (Home, form, 2Df. (City or town)

Not While

gt work ot work 21. I certify that I took charge of the remains described above, held an Autopsy Inspection k Inquiry

Noturol couses X. death resulted from: Accident . Suicide Homicide i Undetermined monner CHIEF MEDICAL EXAMINER

ACTUAL ASSISTANT MEDICAL EXAMINER SIGNATURE FOR DEPUTY MEDICAL EXAMINER **EXAMINER'S** 

WELTY Address (Street, city, town, or county) NAME (Type 23d. LOCATION (City or Town)

23c. NAME OF CEMETERY OR CREMATORY 23b. DATE THEREOF BURIAL, CREMATION, REMOVAL (Specify) UEEN

24. FUNERAL DIRECTOR ADDRESS

250. REC/O BY REGISTRAR 0 1966 (County) (Stote)

19. WAS AUTOPSY PERFORMED?

NO X

(Stote)

ond in my opinion

22. DATE SIGNED

10-24-66

YES [

(County)

2Sb. REGISTRAR'S SIGNATURE

VR A15ME (5)

50

may be retained far yaur FUNERAL DIRECTOR: Page

the funeral directar.

And the second and it says in a second and it seems and it says in a second and it seems and it

.

Selal Salvens

-1 fit

ale a fallent A

11711

- 25

Pro All

100

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or emoval, and in any event, within 72 hours after death. TO HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

|     | 1. PLACE OF DEATH a. COUNTY  | 2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)                                    |
|-----|--|--|
| 1   | 7-11-04  | a. STATE Manuland. b. COUNTY Talbat  |
| -   | b. CITY OR TOWN (if outside corporate limits.   c. LENGTH OF STAY IN 1b  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)   |
|     | Write RURAL and give nearest town)   | Easton 20 - 1  |
| -   | d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)   | d. STREET ADDRESS e. IS RESIDENCE  |
| 0   | 414 S. Aurora Street   | 414 S. Aurona Street YES NO K  |
|     | 3. NAME OF DECEASED (Type or print) Many Eleanor Stevens   | Last 4. DATE Month 10/18 Year DEATH 10/18 1966   |
|     | 5. SEX Female 6. COLOR OR RACE 7. MARRIED NEVER MARRIED 2 8 White WIDOWED DIVORCED   | 8. DATE OF BIRTH 9. AGE (In years IFUNDER 1 YEAR IF UNDER 24 HRS. 46 Months Days Hours Min.                              |
|     | 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)  Antist  | 11. BIRTHPLACE (County & State, or foreign country) 12. CITIZEN OF WHAT COUNTRY?   |
|     | 13. FATHER'S NAME  J. Albert Stevens   | 14. MOTHER'S MAIDEN NAME Kathleen Morris   |
|     | (Vas no or unknum) [/16 vas niva was no datas of causion)  | INFORMANT Address Address Levell, Honolulu, Hawaii   |
|     | 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).  PART I. DEATH WAS CAUSED BY:  IMMEDIATE CAUSE (a)  DUE TO  Conditions, If any, which (b)   | interval between onset and death year  |
|     | gave rise to immediate cause (a), stating the underlying cause last.   | left breast. 2 2 gp.   |
|     | PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO DEATH BUT NOT REL | TED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) 19. WAS MUTOPSY PERFORMED?  YES NO NO                           |
| - 1 |  | RRED. (Enter nature of Injury in Part I or Part II of Item 18.)  |
|     |  | CE OF INJURY (Home, farm, 2Df. (City or town) (County) (State) ry, street, office bldg., etc.)                           |
|     |  | March, 1965, to Oct. 18, 1966, that (I) (we) last death occurred at 5 2 M, from the causes and on the date stated above. |
| 1   | 22a. SIGNATURE B. Chiller, M.D.  |  |
|     | 22c. PHYS/CIAN'S<br>NAME (Type)  | BOX 1025 Easton Md.  |
|     | 23a. BURIAL, CREMATION, 23b. DATE THEREOF 23c. NAME OF CEMETERY REMOVAL (Specify) 10/20/1966 Fort Lincoln  | Washington, D.C.   |
| 3   | MURICE E. NEWHAM & SON, Easton, Md.  | DATE OCT 2 1 1966 followles Judge  |

VR A15 (4) 20M 1/65

\*\* . Theathe wave . The The second of the 11.11 Attack the surface of the same con-

, t

MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

| 26   |               | 14745 CERTIFICA  | TE OF DEATH  | 749                           |
|--|---------------|--|--|-------------------------------|
| eat a  | <u>1</u> 1.   | PLACE OF DEATH   | 2. USUAL RESIDENCE (Where deceosed lived, if institution: Residen                          | ce before odmission)          |
| er d   | 1             | O. COUNTY TALBOT MARYLAND  | MARYLAND QUI   | CEN HNNE                      |
| ges  |               | b. CITY OR TOWN (If outside corporate limits, c. LENGTH OF STAY IN 1b write RURAL and give nearest town)   | c. CITY OR TOWN (If outside corporate limits, write RURAL and give                         | e neorest town)               |
| Pa<br>Pa<br>aurs   |               | EASTO 6  | 2 RURAL CHURCH HILL  | 17-2                          |
| in<br>ers.<br>2 h  |               | d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street oddress)   | d. STREET ADDRESS  | e. IS RESIDENCE<br>ON A FARM? |
| pap du /8  |               | Memorial Hospital  |  | YES NO                        |
| vsician and campletely filled in by the tuneral please remave carban papers. Pages 1 and 2 please remay event, within 72 haurs after death 11, and in any event, within 72 haurs after death | 3.            | NAME OF First Middle   | Le Lost 4. DATE Month  | Doy Year                      |
| carb<br>carb   |               | (Type or print) / nomal //   | XILLUUTI DEATH 10-   |                               |
| amp<br>eve<br>eve  | 5.            | SEX 6. COLOR OR RACE 7. MARRIED NEVER MARRIED  | last hirthday) Months  | Doys Hours Min.               |
| any<br>any   | 10            | MALE WHITE WIDOWED DIVORCED DIVORCED LISUAL OCCUPATION (Give kind of work done 10b, KIND OF BUSINESS OR  | 11. BIRTHPLACE (County & Stote, or foreign country) 12. CII                                | TIZEN OF WHAT                 |
| se r<br>din  |               | ripe most of working life, even if retired) INDUSTRY   | (0   | UNTRY? IJ S A                 |
| sicia<br>olea<br>, an  | 13            | RETIRED FARMER   | Delaware   | 0311                          |
| phy:<br>en g<br>aval   | "             | THOMAS N. STUBBS   | , , , , , ,  |                               |
| en H   | 15            |  | 7. INFORMANT Address (/  |                               |
| signed by the attending physician<br>burial-transit permit. Then please<br>burial, crematian, ar remaval, and i  | ()            | (es, no, or unknown) (If yes give wor or dotes of service)   | LEON STUBBS - CHURCH HA  | LL MD.                        |
| t pe atian   |               | 18. CAUSE OF DEATH (Enter only one couse per line for (o), (b), and (c).) PART I. DEATH WAS CAUSED BY:   | 0+0 0.   | ONSET AND DEATH               |
| ansi<br>ansi   |               | IMMEDIATE CAUSE (o)  | of the tung  | 3 moulls                      |
| signed by<br>burial-trar<br>burial, crei   |               | Conditions, if ony, which gove )   | 9  |                               |
| ign<br>ourio   |               | rise to immediate couse (o), DUE TO  |  |                               |
| ta F   |               | stoting the underlying couse (c)   |  |                               |
| s be<br>as t<br>riar   |               | PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED  | TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(0)                                       | 19. WAS AUTOPSY<br>PERFORMED? |
| # S # ()   | NOI           |  |  | PERFORMED?                    |
| cate<br>ar u<br>Hea  | CERTIFICATION | 20o. ACCIDENT WAS UNDERLYING ☐ 20b. DESCRIBE HOW INJURY OCCURR   | ED. (Enter nature of injury in Port I or Port II of item 18.)                              | 10                            |
| ed ed . af   | GE            | OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |                               |
| tach<br>Dept   | MEDICAL       | 20c. TIME OF INJURY Month, Day, Yeor Hour o.m. 20d. INJURY OCCURRED While Not While  | PLACE OF INJURY (Home, form, foctory, street, office bldg., etc.) 20f. (City or town) (Con | unty) (Stote)                 |
| er the   | ×             | p.m. 17 of work 🗀 of work  |  |                               |
| d be St  |               | 21. I certify that (I) (this hospital) attended the deceased from  | 1 aug , 1965 to 27027, 19  | (l) (we) last                 |
| # de #   |               |  | that death accurred at M, from causes ond on t   | ATE SIGNED                    |
| FUNERAL DIRECTOR: After this certificate has been irectar, page 3 shauld be detached far use as the hauld be filed with the State Dept. af Health priar to                                   |               | 220. SIGNATURE Stephen Camp  | ATTENDING MED CTAFF  | 7 Oct 66                      |
| P page   |               | 22c. PHYSICIAN'S NAME (Type) Stephen P. Carney M   | 22d. ADDRESS   | 27. 1966                      |
| d b  |               | The booking of the carmey  |  |                               |
| TO FUNERAL DIRECTOR: After this certificate has been directar, page 3 shauld be detached far use as the shauld be filed with the State Dept. af Health priar ta                              | 23            | 30. BURIAL, CREMATION, REMOVAL (Specify) 23b. DATE THEREOF 23c. NAME OF CEMETERY   |  | (County) (Stote)              |
|  |               | 24 FUNERAL DIRECTOR ADDRESS / APPRESS / APPRES | 2So. REC'D BY REGISTRAR 2Sb. REGISTRAL 3   | IGHNURE Judge                 |
| R A15 (4)  | 2             | agar de Lane Church Hill   | 1/1/12 DATE OCI 31 1968  | 0                             |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death conflicture be executed within 24 haurs after death.

Page 4 may be retained by the haspital ar attending physician.

. .

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 haurs after death.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

|                       | 14746   |   | em ) r.           | CERTI               |             | OF DEA              | TH_             |                     |                  |             | 147                  | 49                    |           |
|-----------------------|---|---|-------------------|---------------------|-------------|---------------------|-----------------|---------------------|------------------|-------------|----------------------|-----------------------|-----------|
| 1.                    | PLACE OF DEATH                                  |   |                   |                     |             | 2. USUAL RESI       | DENCE (Where    | deceosed liv        | red, if institut | ion: Reside | ence befor           | e odmissi             | on)       |
| L                     | 1 alks  | et  |                   | MAR                 | RYLAND      | o. STATE            | Md              |                     | b. COU           | NTY         | Tal                  | bot                   |           |
|                       | b. CITY OR TOWN (                               | If outside corporate limit                    | is,               | c. LENGTH OF STAY   | IN 1b       | c. CITY OR TOV      | VN (If outside  | corporote lim       | nits, write RU   | RAL ond g   | ve neores            | t town)               |           |
| 2                     | ast   | 2   |                   | 2/da                | ys!         | East                |                 |                     |                  |             | 20.                  | /                     |           |
| 1                     | d NAME OF HOSPIT                                | AL OR INSTITUTION (If n                       | ot in hospitol, g | ive street oddress) |             | d. STREET ADD       | RESS            |                     |                  |             |                      | e. IS RESII<br>ON A F | DENCE     |
| 2                     | asto  | n Men   | wall              | The                 | 4/2         | 708                 | Ways:           | ide A               | ve.              |             |                      |                       | NO.       |
| 3.                    | NAME OF<br>DECEASED<br>(Type or print)          | 14  | of he             | Vandedbe            | KK /        | Lost                | 0. 0            | DATE<br>OF<br>DEATH | Mont             | h )         | Doy                  | Yes                   | or<br>/// |
| 5                     | SEX SEX   | 6. COLOR OR RACE                              | 7. MARRIED        | NEVER MARRIE        | D D B       | DATE OF BIRTH       | - 4             |                     | (In years        | I IF UNDER  | 2 1 YEAR             | IF UNDER              | 24 HPS    |
| 1                     | F   | W   |                   | DIVORCE             |             | June/               |                 |                     | Sighthdoy)       | Months      | Doys                 | Hours                 | Min.      |
|                       |   | (Give kind of work done                       |                   | ND OF BUSINESS OR   |             | 11. BIRTHPLACE      | (County & Sto   | te, or foreign      | country)         |             | ITIZEN OF<br>OUNTRY? | WHAT                  |           |
|                       | ring most of working <b>NOUSE</b> FATHER'S NAME | wife  |                   |                     |             | Bri                 | Ldgeto          | on, N               | . J.             |             | USA                  |                       |           |
| 1                     |   | unk.  |                   |                     |             | 14. MOTTICK 3 I     |                 | o le                |                  |             |                      |                       |           |
| 15                    | WAS DECEASED FVE                                | RINILS ARMED FORCES?                          | 16. 5             | OCIAL SECURITY NO.  | 17. IN      | FORMANT             | u,              | ık.                 | Addre            | 255         |                      |                       |           |
|                       |   | (If yes give wor or dotes                     | of service)       |                     | 74 5        | Duran               |                 | 7 0                 |                  | VE          |                      |                       |           |
|                       | no  | ATU (F )                                      |                   | 7-18-84             | ת-0/        | Russ                | sell I          | 1. 00               | OK E             | asto        |                      | Md.                   |           |
|                       | PART I. DEAT                                    | EATH (Enter only one cou<br>TH WAS CAUSED BY: | 40                |                     |             |                     | . /             | 1                   |                  | -           |                      | ERVAL BET             |           |
|                       | Bar.  | IMMEDIATE CAUSE                               | (0)               | ute p               | YOC         | arajo               | al 1.           | nTRI                | cli              | OH          | 12                   | Lda                   | refe      |
|                       | Cartha Tal                                      | DUE   | 10                | cereor              | act of      | gow                 | Jany.           | //                  |                  |             |                      | 11 3                  | /         |
|                       | Conditions, if ony, rise to immediat            | e couse (a)                                   | (b)               | encree              | ezel,       | are                 | ezgeo           | ach                 | rea              | es          | -                    | Yea                   | EX        |
|                       | stoting the under                               |   | TO /              |                     | 0 4         |                     |                 |                     |                  |             | 1                    |                       |           |
|                       | last.   | )   | (c)               |                     |             |                     |                 |                     |                  |             |                      |                       |           |
| z                     | PART II. OTHER SI                               | GNIFICANT CONDITIONS                          | ONTRIBUTING TO    | DEATH BUT NOT RE    | LATED TO TH | IE TERMINAL DISI    | EASE CONDITIO   | N GIVEN IN I        | PART 1(o)        | 7           | 19.                  | WAS AUTO<br>PERFORME  |           |
| ATI0                  | Diale   | eles mi                                       | eller             | us de               | nel         | no per              | ermen           | 1. H                | merce            | lear        | · Tyl                |                       | NO X      |
| E                     | 20o. ACCIDENT WAS                               |   | 20b. DES          | CRIBE HOW INJURY O  | CCURRED. (E | inter fature of in  | njury in Port I | of Port II of       | (sem 18.)        | 00.00       |                      |                       |           |
| E                     |   | CAUSE OF DEATH MEDICAL EXAMINER)              |                   |                     |             |                     |                 | 0                   |                  |             |                      |                       |           |
| MEDICAL CERTIFICATION | -   | JRY Month, Doy, Year                          | 20d. IN.          | JURY OCCURRED       | 20e. PLACE  | OF INJURY (Ho       | me. form.       | 20f. (City          | or town)         | 1Cc         | ounty)               | T.                    | Stote)    |
| WED                   | Hour a.n  | n.  | While             | - Not While         |             | y, street, office b |                 |                     | ,                | 1           | · · · · · //         | 1.                    | 510101    |
| 1                     | p.n   | 11.   | atwork            |                     | ,           | 12-11               | / 10/           | /                   | 7.10             | 7 10        | 11                   |                       |           |
|                       |   | fy that (I) (this has eceased alive an_       | pital) attend     | ed the deceased     | and that    | death occur         | , 19 <i>Ce</i>  | 19 0M fra           | 7273             | , 190       | the date             | at (I) (v             | ve) la    |
|                       | 220. SIGNATURE                                  | Coused drive dri_                             | 2 2 -             | 10                  | and mar     | deam occor          | 2               | 7 m, 11u            | 111 (40363       |             | ATE SIGN             |                       | ubov      |
|                       | La Car  | Jole &  | tel               | there -             | M.D.        | ATTENDING<br>PHYS.  | MED.            | CTOR .              | STAFF PHYS.      | N           | DV.                  | 1 1/5                 | 2/1       |
|                       | 22c. PHYSICIAN'S                                | and .   | 1000              |                     | B1.D.       | 22d. ADDRI          |                 | IIOK (L)            | rnis. L          | 1 / 1       | - 20                 | 11                    |           |
|                       | NAME (Type)                                     |   | Kollma            | n. M.D.             |             | Ea                  | ston,           | Md.                 |                  |             |                      |                       |           |
| 22.                   | b. BURIAL, CREMATIO                             |   |                   | 23c. NAME OF CEM    | ETERY OR CE |                     |                 |                     | N (City or Toy   | lau         | If aunt 1            | le.                   | letel.    |
| 23                    | PEMOVAL (Specify)                               |   |                   |                     |             | CMATUKT             |                 |                     |                  |             | (County)             | (51                   | tote)     |
| -                     | BUT181  |   | /66               | Overlo              | ok          | Lac                 | o. REC'D BY I   | Bric                | igeto            | n N         | T                    |                       |           |
| The                   | FUNERAL DIRECTO                                 | 1 2   | 14 g              | ADDRESS             | 1 10        |                     |                 |                     |                  | GISTRAR'S   | SIGNATUR             | Quel                  | 42        |
| 11                    | Mr. amples                                      | La SPIN                                       | 111 6             | 112 cou 1 1         | Nd.         | D/                  | ATE NOV         | 4                   | 966              | 4 mas       | my                   | X TO                  |           |

1966

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral directar, page 3 shauld be detached far use as the burial-transit permit. Then please remave carban papers. Pages 1 and 2 shauld be filled with the State Dept. at Health priar to burial, crematian, or removal, and in any eyent-within 72 haurs after death. Page 4 may be retained by the haspital ar attending physician. VR A15 (4) 20 M 1/66

a source H. april

6" " " . But shirt see See - Day , nosaga \_ Moro . h. Alfaam \_ C-olic-Masset

MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 CERTIFICATE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission PLACE OF DEATH a. COUNTY b. COUNTY MARYLAND b. CITY OR TOWN (If autside carparate limits, c. LENGTH OF STAY IN 16 c. CITY OR TOWN (If autside carparate limits, write RURAL and give nearest tawn) write RURAL and give nearest tawn) Baltimore 9510 e. IS RESIDENCE ON A FARM? d. NAME OF HOSPITAL OR INSTITUTION (If nat in haspital, give street address d. STREET ADDRESS Granada YES NO I 3. NAME OF Middle 4. DATE Month Day Year DECEASED OF DEATH (Type or print) IF UNDER 24 HRS SFX 6. COLOR OR RACE 7. MARRIED NEVER MARRIED DATE OF BIRTH 9. AGE (In years IF UNDER 1 YEAR last birthday) Manths Davs Hours lorea WIDOWED DIVORCED 10b. KIND OF BUSINESS OR 10a, USUAL OCCUPATION (Give kind of work done 12. CITIZEN OF WHAT 1). BIRTHPLACE (County & State, or foreign country) during most of warking life even if retired) INDUSTRY COUNTRY? Domestic 13. FATHER'S NAME 14. MOTHER'S MAIDEN Emma Warren 15. WAS DECEASED EVER IN U.S. ARMED FOR CES?
(Yes, na, ar unknawn) (If yes give war ar dates af service) 16. SOCIAL SECURITY NO. **INFORMANI** Address man-3007 Granada no 1B. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) INTERVAL BETWEEN ONSET AND DEATH PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) DUE TO Canditians, if any, which gave rise to immediate cause (a). DUE TO stating the underlying cause last. WAS AUTOPSY PERFORMED? PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) CERTIFICATION NO 20g. ACCIDENT WAS UNDERLYING 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) MEDICAL 20c, TIME OF INJURY Month, Day, Year 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Hame, farm, 20f. (City or town) (Caunty) (State) Haur a.m. While Not While factory, street, affice bldg., etc.) 19 at work at wark 21. I certify that (I) (this haspital) attended the deceased fram 19\_\_\_, that (1) (we) last ta. 15 mm, from causes and an the date stated above. saw the deceased alive an. and that death accurred at

campletely filled in by the funeral nave carban papers. Pages 1 prid emave carban papers. Pages 1 any event, within 72 haurs after remave carban and plense crematian, signed by the burial-transit p burial, priar ta as the has been TO FUNERAL DIRECTOR: After this certificate be retained by the haspital ar far detached State Dept. pe shauld director, page shauld be filed Page 4 may

law requires that the death certificate be executed within 24 haurs after death

deoth

Bra

20 M 1/66

v10 24. FUNERAL/DIRECTOR

22a. SIGNATURE

22c. PHYSICIAN'S

23g. BURIAL, CREMATION,

REMOVAL (Specify)

NAME (Type)

23b. DATE THEREOF

Robert W. Trever

23c. NAME OF CEMETERY OR CREMATORY ADDRESS 2Sq. REC'D BY REGISTRAR

M.D.

23d. LOCATION (City or Town)

DIRECTOR

(County)

STAFF

PHYS.

2Sb. REGISTRAR'S SIGNATUR

22b. DATE SIGNED

ATTENDING

PHYS. 22d. ADDRESS 147741 Sent Bir a set that 

CHOPERT ON SUCCESS CHARLES OF THE

# MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

|                       | 14748   | CERTIFICATE                           | OF DEATH   | 14  | 751                                     |  |  |  |
|-----------------------|---|---------------------------------------|--|---|---|--|--|--|
|                       | PLACE OF DEATH O. COUNTY TO-160 T   | MARYLAND                              | a. STATE Mary  | ere deceased lived, if institution: Reside<br>b. COUNTY | nce befare admission)                   |  |  |  |
|                       | b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest tawn)  | C. LENGTH OF STAY IN 16               | c. CITY OR TOWN (If Juts)                                    | de corparate limits, write RURAL and giv                | re nearest town)                        |  |  |  |
|                       | d. NAME OF HOSPITAL OR INSTITUTION (If not in   | hospital, give street address)        | d. STREET ADDRESS  RFD =                                     | , Box #214  | e. IS RESIDENCE<br>ON A FARM?<br>YES NO |  |  |  |
|                       | NAME OF First DECEASED (Type or print)  Print Les Miles   | ev Sybilla V                          | Valter   | 4. DATE Manth OF DEATH OCT -                            | 24 1966                                 |  |  |  |
| S.                    |   | MAKRIED NEVER MARRIED                 | April 13, 18   | 9. AGE (In years last birthday) Months yrs.             | Days Haurs Min.                         |  |  |  |
| duri                  | . USUAL OCCUPATION (Give kind af wark dane<br>ing most af warking life, even if retired)  | 10b. KIND OF BUSINESS OR INDUSTRY     | Baltimore  | Con Maryland  | DUNTRY?                                 |  |  |  |
|                       | John Frederic   | k Heintzman                           |  | Elenora Bol   | te                                      |  |  |  |
|                       | WAS DECEASED EVER IN U.S. ARMED FORCES?<br>is, na, ar unknown) (If yes give war or dates af sen   |                                       | NFORMANT<br>Grace Viola                                      | WalterYox; E  | Box #22<br>aston, Md.                   |  |  |  |
|                       | 18. CAUSE OF DEATH (Enter only one cause per PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)  ### DUE TO Canditions, if any, which gave ) (b)  | Acute myo                             | cardial rotic he   | infarction art disease                                  | INTERVAL BETWEEN ONSET AND DEATH        |  |  |  |
|                       | rise to immediate couse (a), stating the underlying cause act.    DUE TO  |                                       |  |   |   |  |  |  |
| ATION                 | PART II. OTHER SIGNIFICANT CONDITIONS CONTR   | IBUTING TO DEATH BUT NOT RELATED TO T | HE TERMINAL DISEASE CONDI                                    | TION GIVEN IN PART 1(a)                                 | 19. WAS AUTOPSY PERFORMED?  YES NO      |  |  |  |
| MEDICAL CERTIFICATION | 20a. ACCIDENT WAS UNDERLYING ☐<br>OR CONTRIBUTING ☐ CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  | 20b. DESCRIBE HOW INJURY OCCURRED. (  | Enter noture of injury in Po                                 | rt I or Part II of item 18.)                            |   |  |  |  |
| MEDICA                | 20c. TIME OF INJURY Manth, Day, Year<br>Haur o.m.<br>p.m. 19  |                                       | E OF INJURY (Hame, farm,<br>pry, street, affice bldg., etc.) | 20f. (City or town) (Ca                                 | unty) (State)                           |  |  |  |
|                       | 21. I certify that (1) (this haspital) attended the deceased fram Deca 23, 1966 to Oct 24, 1966, that (1) (and last saw the deceased alive on Oct, 24, 1966, and that death accurred at 123M, fram causes and on the date stated above. |                                       |  |   |   |  |  |  |
|                       | 220. SIGNATURE DALE R. A  | ollman M.D                            | ATTENDING M<br>PHYS. DI                                      | ED. RECTOR PHYS.   22b. D                               | ATE SIGNED<br>26, 24, 1966              |  |  |  |
|                       | NAME (Type) Dale K.   | Kollman, Md                           | ? 12 Ni.   | Hanson; East  | 7710                                    |  |  |  |
|                       | Burial, CREMATION, REMOVAL Specify) 10/27/6   | 6 St. Paul's                          | Cemetery   | 23d. LOCATION (City or Town)  Balto. Co                 | 0.0 00                                  |  |  |  |
| 24                    | FUNERAL DIRECTOR Tipton-Eline   | Hampstead, Md.                        | 2Sa. REC'D B   | am a a chan Mal   | ignature Judge                          |  |  |  |

O HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 haurs after death.

Page 4 may be retained by the haspital ar attending physician.

VR A15 (4) 20 M 1/66

TO FUNERAL DIRECTOR: After this certificate has been signed by the aftending physician and campletely filled in by the funeral director, page 3 shauld be detached for use as the burial-transit pears. Then please remave carban papers. Pages 1 and shauld be filed with the State Dept. of Health prior to burial, cremarkan, or remaval, and in any event, within 72 haurs after dear

3 4 6 The foreign of the first of the

MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 MEDICAL EXAMINER'S CERTIFICATE OF DEATH HEALTH DEPT 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) 1. PLACE OF DEATH a. COUNTY TALBOT b. COUNTY TALBOT a STATE Page ond 3 ta ō death. MARYLAND deloy i State Department c. LENGTH OF STAY IN 1b. c. CITY OR TOWN (If autside corporate limits, write RURAL and give nearest tawn) b. CITY OR TOWN (If autside corporate limits, P.M.3. write RUPAL and give nearest tawn) DOA EASTON RD d. STREET ADDRESS IS RESIDENCE ON A FARM? d. NAME OF HOSPITAL OR INSTITUTION (If nat in haspital, give street address) hours MEMORIAL HOSPITAL CORDOVA ROAD YES NO K 24 hours ofter death. 3. NAME OF Middle First 4. DATE Month Year DECEASED PATRICIA WATTS 166 ANN OCTOBER 19 within (Type ar print) IF UNDER 1 YEAR 9. AGE (In years IF UNDER 24 HRS 6. COLOR OR RACE 7. MARRIED NEVER MARRIED B. DATE OF BIRTH last birthday) Ded. 30.1938 WIDOWED DIVORCED 10h KIND OF BUSINESS OR 11. BIRTHPLACE (State or foreign country) 12. CITIZEN OF WHAT 10a. USUAL OCCUPATION (Give kind af work dane COUNTRY? during mast af working life, even if retired) INDUSTRY St. Michaels. Md. ony USA e, writing the ward "pending" in pencil in forworded to the Chief Medical Examiner's poges in ony 14. MOTHER'S MAIDEN NAMI 13. FATHER'S NAME should be executed within Julian E. Wayman Anna Doris Horney ond 17 INFORMANT 16. SOCIAL SECURITY NO. (Yes, na, orunknawn) (If yes give war ar dates af service or removal, Julian E. Wayman, St. Michaels. INTERVAL BETWEEN 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) buriol-transit ONSET AND DEATH PART I. DEATH WAS CAUSED BY: SEVERE HEAD ETC, INJURIES IMMEDIATE CAUSE (a) cremation, AUTO ACCIDENT Conditions, if any, which gave rise ta immediate cause (a), DUE TO stating the underlying cause 0 buriol, 19. WAS AUTOPSY PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) PERFORMED? please execute the certificate, NO pe ogent, prior to 4 should be 20g. EXTERNAL CAUSE WAS 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Port I or Part II of item 18.) 3 should PRIMARY Or CONTRIBUTING OF CAR WHICH SKIDDED ON WET ROAD&STRUCK ANOTHER CAUSE OF DEATH. 20e. PLACE OF INJURY (Hame, farm, 20f. (City ar town) 20c. TIME OF INJURY Manth, Day, Year (State) Oxford Road Nat While p.m. 10-19 166 at wark 2 nr Easton Talbot Md at wark its designated Inspection x, Inquiry, 21. I certify that I took charge of the remains described above, held an Autopsy and in my apinion Natural causes , Accident X, Suicide , Homicide the funerol director. death resulted fram: Undetermined manner CHIEF MEDICAL EXAMINER ACTUAL 22. DATE SIGNED ASSISTANT MEDICAL EXAMINER SIGNATURE 10-19-66 for DEPUTY MEDICAL EXAMINER XX 0 **EXAMINER'S** Louis S. Weltv Address (Street, city, tawn, ar county) Heolth NAME (Type) NAME OF CEMETERY OR CREMATORY 23a. BURIAL, CREMATION 23d. LOCATION (City or Town) (County) (State) 2 2Sb. REGISTRAR'S SIGNATUR 2Sq. REC'D BY REGISTRAR VR A15ME (5) DATE OCT

9

2

THE BUT OF BUILDING X

A THE REST OF STREET, A PARTY OF STREET, AS A STREET, AS

2.11.5

.

# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

| . (25)   | 1  |       | 14750  | CERTIFICATE OF DEATH   | 14753   |   |  |  |
|--|----|-------|--|--|---|---|--|--|
| PHYSICIAN: The law requires that the death certificate be executed within 24 haurs after death. e haspital ar attending physician. as the death of the certificate has been signed by the attending physician and campletely filled in by the funeral stacked for use as the burial-transit permit. Then blease remave carban papers. Pages 1 and 2 Dept. at Health priar ta burial, crematian, or remavel, and in any event, within 72 haurs after deaths.  | )  |       | PLACE OF DEATH Jackot  | 2. USUAL RESIDENCE (Where deceosed lived, if institution: Residence o. STATE)  MARYLAND  MARYLAND                  | before odmission)   |   |  |  |
| cuted within 24 haurs after of ampletely filled in by the fur ve carban papers. Pages 1 event, within 72 haurs after   |    |       | o. CITY OR TOWN (If outside corporate limits write RURAL and give negrest town)            | c. LENGTH OF STAY IN 1b) c. CITY OR TOWN (If outside corporate limits, write RURA) and give Stevensville           | neorest town)   |   |  |  |
| led in Sapers.   | 78 | 1     | I NAME OF HOSPITAL OR INSTITUTION (IF A  | t in hospital give street address d. STREET ADDRESS  | e. IS RESIDENCE<br>ON A FARM?<br>YES NO                   |   |  |  |
| withir<br>etely fil<br>arban<br>pt, with   |    |       | NAME OF DECEASED Type or print) Tuand  | e E. White DEATH 10/11   | Doy Year  |   |  |  |
| executed with  |    | S.    | SEX 6. COLOR OR RACE  EMALE WHITE  | WIDOWED DIVORCED 1/01/1-1882 83 Yrs.   | Doγs Hours Min  |   |  |  |
| ate be exercian and a<br>lease rema  |    |       | USUAL OCCUPATION (Give kind of work done ng most of working life, even if retired)         | 10b. KIND OF BUSINESS OR II. BIRTHPLACE (County & Stote, or foreign country)  MARY LAND  12. CITIL COU             | ZEN OF WHAT<br>NJRY?<br>A                                 |   |  |  |
| certifica<br>pabysic<br>men<br>mover   |    |       | FATHER'S HAME !<br>RICHARD   | KELLY LAURA J. BRIGHT  |   |   |  |  |
| equires that the death physician. signed by the attending burial-transit permit. burial, crematian, or re-   |    |       | WAS DECEASED EVER IN U.S. ARMED FORCES?<br>s, no, or unknown) (If yes give wor or dotes of | f service) 16. SOCIAL SECURITY NO. 17. INFORMANT RICHARD K. WHITE -TRAPPE  | Mo.   |   |  |  |
| that the ian. by the a transit per crematia  | ,  | 2     | 18. CAUSE OF DEATH (Enter only one cou<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE  |  | ONSET AND DEATH   |   |  |  |
| physicial<br>physicial<br>signed b<br>burial-tra<br>burial, cr   | V  |       | Conditions, if ony, which gove rise to immediate couse (o),                                | TO (b)   |   |   |  |  |
| ding plansing plansin |    |       | stoting the underlying couse bast.   | TO (c)   |   |   |  |  |
| AN: The law ratending icate has been for use as the Health priar ta  | 0  | ATION | PART II. OTHER SIGNIFICANT CONDITIONS C  | DISTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(0)                         | 19. WAS AUTOPSY PERFORMED? YES NO                         |   |  |  |
| SICIAN<br>Ispital of<br>ertification<br>and far<br>t. of He  |    |       |  |  | L CERTIFICATION   | 200. ACCIDENT WAS UNDERLYING □<br>OR CONTRIBUTING ☑ CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port II of item 18.)  Feel at House in Fine. |  |
| DING PHYSI by the hasp After this cer be detached State Dept. (  |    |       |  | MEDICAL  | 20c. TIME OF INJURY Month, Doy, Yeor<br>Hour o.m.<br>p.m. | 20d. INJURY OCCURRED  20e. PLACE OF INJURY (Home, form, while of work | albut me   |  |
| TENDIP<br>ined by<br>R: Aftr<br>ould be<br>the Str   |    |       | 21. I certify that (I) (this has saw the deceased alive on_                                | pital) attended the deceased from 1963, 19, ta 1184, 1960, and that death accurred at 1900, from causes ond on the | e date stated aba   |   |  |  |
| O HOSPITAL OR ATTENI<br>age 4 may be retained<br>FUNERAL DIRECTOR: A<br>director, page 3 should<br>should be filed with the  |    |       | 220. SIGNATURE Reptor C  | M.D. ATTENDING MED. STAFF  | TE SIGNED   |   |  |  |
| HOSPITAL age 4 may FUNERAL I irectar, pag hauld be fil   | 1  |       |  | P. Carney M. D. 22d. ADDRESS Easton, Maryland Oct. 12  |   |   |  |  |
| TO HOSPITAL Page 4 may b TO FUNERAL D director, page shauld be file  | 0  | -     | BURIAL, CREMATION, 23b, DATE THI   | 14 STEVENSVILLE STEVENSVILLE   | County) (Stote)   |   |  |  |
| VR A15 (4)<br>20 M 1/66  | B  | 24    | Edgar Le Lan   | 2 Cherch fill Mad DATE OCT 1966 Peristrans SIG   | les Judge   |   |  |  |

-G = 1 1425.6 do from the state of the first production of the state of

The state of the last

Pilita on Paris

# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

|   | 14751  | CERTIFICATE OF DEATH   |  | 4754                                |
|---|--|--|--|-------------------------------------|
| Tuneral<br>Tand<br>er déath   | 1. PLACE OF DEATH o. COUNTY  | 2. USUAL RESIDENCE<br>o. STATE   | (Where deceosed lived, if institution: Reside                  |                                     |
| s l<br>ffer   | b. CITY OR TOWN (If outside corporate limits,  | MARYLAND /// O/12  | uland Baltimo<br>outside corporate limits, write RURAL and giv | re                                  |
| Pages<br>prages<br>presoft  | write RURAL and give nearest town)   | 3 days. Parkvi   |  | re neorest rown)                    |
| in by<br>rs.<br>2 hou   | d. NAME OF HOSPITAL OR INSTITUTION (If not in  |  |  | e. IS RESIDENCE                     |
| lled in 72 in 72  | Merrovial  | Hosp., Easton 2105 Tag   | ylor Ave.  | ON A FARM? YES NO                   |
| completely filled<br>ove carbon pape<br>y event, within 7   | 3. NAME OF DECEASED (Type or print) Hugh. First  | mitebell Woodless,   | 4. DATE Month OF DEATH   | Day Year<br>15 19 (6 6              |
| cian ond completely filled in by the fur<br>eose remove carbon papers. Pages I<br>ond in ony event, within 72 hours offer   | M - / -  | MARRIED NEVER MARRIED B. DATE OF BIRTH VIDOWED DIVORCED 7/9/1880   | 9. AGE (In yeors   IF UNDER   dost birthdoy)   Months          | Doys Hours Min.                     |
| ian ond<br>ose rem<br>nd in on  | 10o. USUAL OCCUPATION (Give kind of work done during most of working life, even if policed),   | 10b. KIND OF BUSINESS OR 11. BIRTHPLACE (Counting Wood Maryla  | 1 160  | TIZEN OF WHAT<br>OUNTRY?            |
| bhys<br>en se   | 13. FATHER'S NAME John Wootten   | 14. MOTHER'S MAIDEN  | NAME 2   |                                     |
| by the ottending<br>ransit permit.  | 15. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(Yes, no., or unknown) (If yes give wor or dotes of ser   | vice) 16. SOCIAL SECURITY NO. 17. INFORMANT 219164411 Mrs. W. E  | . Wheat- 2105 To   | ylor Ave.                           |
| signed by the ottendi<br>burial-transit permit.<br>burial, crematian, or r  | 1B. CAUSE OF DEATH (Enter only one couse poper part I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (o)  | er line for (a) (b) and (d)  | chestic  | INTERVAL BETWEEN<br>ONSET AND DEATH |
| signed by the<br>burial-transit<br>burial, cremat   | Conditions, if ony, which gove )  (b)  | reples fathy   |  | (;)                                 |
| een sign<br>the bur<br>or to bur  | nse to immediate couse (a), stating the underlying couse last.   | Aghostitic premuia   |  | 3 kg                                |
| <b>FUNERAL DIRECTOR:</b> After this certificate has been directar, page 3 should be detached for use os the should be filed with the Stote Dept. of Health prior to | PART II. OTHER SIGNIFICANT CONDITIONS CONTR  | RIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE (  | ONDITION GIVEN IN PART I(o)                                    | 19. WAS AUTOPSY PERFORMED? YES NO   |
| ertification for the form   | NO SECOND TWO SECOND SE | 205. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in  | Port I or Port II of item 18.)                                 |                                     |
| r this c<br>detach<br>ite Depi  | 20c. TIME OF INJURY Month, Doy, Yeor<br>Hour o.m.<br>p.m. 19   | 20d. INJURY OCCURRED   20e. PLACE OF INJURY (Home, for While at work   10 twork   10 t |  | ounty) (Stote)                      |
| R: Afte   |  | l) attended the deceased fram 17 0cf ,<br>40 cf 1966, and that death accurred a  | 19 66 to 13 Oct , 196<br>11 2 4 M, fram causes and an 1        | the date stated abave.              |
| IRECTO<br>3 sho<br>d with   | 220. SIGNATURE   | M.D. ATTENDING M.D. PHYS.  | MED. DIRECTOR PHYS. 22b. D                                     | PATE SIGNED COLOR 46                |
| ERAL D  | 22c PHYSICIAN'S<br>NAME (Type) / HURSTOW   | HARRISON 22d. ADDRESS  | In boy land  |                                     |
| ro Funeral Dire   | 230. BURIAL, CREMATION, 23b. DATE THEREO BREMOVAL (Specify) 10/18/   |  | 23d. LOCATION (City or Town) Baltimore Co.                     | (County) (Stote)                    |
| VR A15 (4)<br>20 M 1/66   | 24. FUNERAL DIRECTOR   | 11 1 1 1   | CT 19 1966 CLICA   | SIGNATURE Judge                     |
| 20 M 1/00   | Leonard J. Ruck Ind  | DATE U   | OI TO 1000 1-  | 10                                  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospitol or attending physician.

| The second second                     | 10 Te 11 1927. 3 | 12 9843 (144s       |             |              |
|---------------------------------------|------------------|---------------------|-------------|--------------|
| 14754                                 |                  |                     |             |              |
|                                       |                  |                     | Maria Danie |              |
|                                       |                  | Addition and a con- |             |              |
|                                       | 0.1.21           | Jan L. Salin        |             |              |
|                                       | Land             |                     |             |              |
|                                       |                  |                     |             | K-1 (= 1)    |
|                                       |                  | 100                 |             |              |
|                                       |                  |                     |             |              |
|                                       |                  | ,                   |             |              |
|                                       |                  | A - 4 4 6           |             |              |
|                                       |                  |                     |             | 90.0         |
|                                       |                  |                     |             |              |
|                                       |                  |                     |             |              |
|                                       |                  |                     |             |              |
|                                       |                  |                     | A POST OF   | from 1521 to |
|                                       | Maritim .        |                     |             |              |
| The four                              |                  | 10311               | 1600 2-40   |              |
| · · · · · · · · · · · · · · · · · · · | THE RESERVE TO   | 0.00                |             |              |
| 3000                                  | Admir DA se      |                     |             | A CHARLE     |

MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

11755

| L             | 18100   | CERTIFICATE                          | OI DEATH  |                                 | 14             | 40.1                 |  |  |
|---------------|---|--------------------------------------|---|---------------------------------|----------------|----------------------|--|--|
| 1.            | PLACE OF DEATH  |                                      | AL RESIDENCE (Where deceased lived, if institution: Residence before admission) |                                 |                |                      |  |  |
| 4             | a. COUNTY TALBOT  | MARYLAND                             | O. STATE DELA   | MAPE b. COUNT                   | 0              |                      |  |  |
| -             | b. CITY OR TOWN (If outside carporate limits,   | c. LENGTH QF STAY IN 1b              | c. CITY OR TOWN (If outside   | de carparate limits, write RUR/ |                | screst town)         |  |  |
|               | write RURAL and give pegrest town)  | 3 days                               | 00  |                                 | 0.             |                      |  |  |
| -             | d. NAME OF HOSPITAL OR INSTITUTION (If not in h   | a gays.                              | d. STREET ADDRESS   | VWOOD                           | KUR            | e. IS RESIDENCE      |  |  |
| ,             | d. NAME OF MOSPITAL OR INSTITUTION (II III III)   | ospiidi, give sireer dudress;        | d. SIKEEL ADDRESS   |                                 | 11             | ON A FARM?           |  |  |
|               | Memorial  | Moderal                              |   | 4                               | 10.3           | YES NO               |  |  |
| 3             | NAME OF DECEASED  | Middle                               | Last / 4  | . DATE Month                    | ,              | Day Year             |  |  |
|               | (Type or print)   |                                      | LOTT  | DEATH OCT                       | - /            | 1 19 66              |  |  |
| S             | . SEX 6. COLOR OR RACE 7. M   | MARRIED NEVER MARRIED 8              | 3. DATE OF BIRTH  | 9. AGE (In years                | Months Day     |                      |  |  |
|               | -EMALE WHITP W  | IDOWED DIVORCED                      | MAV 15 188  | 9 lost birthday)                | Months Day     | ys Haurs Min,        |  |  |
|               | Oa. USUAL OCCUPATION (Give kind af wark dane  | 10b. KIND OF BUSINESS OR             | M. BIRTHPLACE (County & St  | tate, or fareign country)       | 12. CITIZEN    |                      |  |  |
| di            | uring most of warking life, even if refired)  | INDUSTRY                             | GREENWOO  | OD DELL                         | COUNTR         | Y 4.                 |  |  |
| 7             | 3. FATHER'S NAME  |                                      | 14. MOTHER'S MAIDEN NAM   |                                 | 1.             |                      |  |  |
|               | FOEDINI West  | EU HOUD                              | EMMA /  | BATURDIU                        | - Ll           | 1110                 |  |  |
| 1             | S. WAS DECEASED EVER IN U.S. ARMED FORCES?  | 16. SOCIAL SECURITY NO. 17. II       | NFORMANT  | Addres                          | 10             | LUIS                 |  |  |
|               | Yes, no, or unknown) (If yes give war ar dotes of servi                                       |                                      | D'and D   | 2                               |                | 0/                   |  |  |
|               |   |                                      | HIRLE / D   | AILEY GRE                       | ENWOOD         |                      |  |  |
|               | <ol> <li>CAUSE OF DEATH (Enter only one cause per<br/>PART 1. DEATH WAS CAUSED BY:</li> </ol> |                                      | 1   |                                 |                | INTERVAL BETWEEN     |  |  |
|               | IMMEDIATE CAUSE (a)   | Cardian fail                         | ene   |                                 |                | ONSET AND DEATH      |  |  |
|               | (anditions, if any, which gave) DUE TO Caron are all us 3 chartie heat discare (?             |                                      |   |                                 |                |                      |  |  |
|               | Canditians, if ony, which gove ) (b)  | Coron my all in                      | oseumic   | men my a                        | ue             | ( )                  |  |  |
|               | rise to immediate cause (a), stating the underlying cause                                     |                                      |   |                                 |                |                      |  |  |
|               | last. (c)   |                                      |   |                                 | (90)           |                      |  |  |
| -             | PART II. OTHER SIGNIFICANT CONDITIONS CONTRIL   | BUTING TO DEATH BUT NOT RELATED TO T | HE TERMINAL DISEASE CONDIT  | ION GIVEN IN PART I(a)          |                | 19. WAS AUTOPSY      |  |  |
| 101           |   |                                      |   |                                 |                | PERFORMED? YES NO    |  |  |
| CERTIFICATION | 20a. ACCIDENT WAS UNDERLYING □  | 20b. DESCRIBE HOW INJURY OCCURRED. ( | Enter noture of injury in Part  | I or Part II of item 18.)       |                |                      |  |  |
| FPT           | OR CONTRIBUTING CAUSE OF DEATH  |                                      |   |                                 |                |                      |  |  |
|               |   | 20d. INJURY OCCURRED 20e. PLAC       | E OF INJURY (Hame, farm,  | 20f. (City or town)             | (County)       | (State)              |  |  |
| MFDICAL       | Haur a.m.   | While Nat While facto                | ry, street, office bldg., etc.)   | (c., or lown)                   | (coomy)        | (31016)              |  |  |
|               | p.m. 17   | atwark U ot work U                   | 14 000  | 11 10 11                        | 10//           |                      |  |  |
|               | 21. I certify that (I) (this haspital)  | ) affended the deceased fram         | 19007 , 190   | M, fram causes a                |                | , that (I) (we) last |  |  |
|               | saw the deceased alive an 16  | 19 <u>66</u> , and Indi              | death accurred at   | m, from couses o                |                |                      |  |  |
|               | Thurston Harris   |                                      | ATTENDING ME  |                                 | 22b. DATE S    | A                    |  |  |
| 13            |   | Ker M.D                              | PHYS. DIR   | RECTOR L PHYS. L                | 110            | 466                  |  |  |
| г             | 22c. PHYSICIAN'SNAME (Type)   HURSTON   | HARRISON                             | 220. ADDRESS  | un the mes.                     | land           |                      |  |  |
| -             |   |                                      | Cash  |                                 |                |                      |  |  |
| 23            | 30. BURIAL, CREMATION, 23b. DATE THEREOF  | 23c. NAME OF CEMETERY OR C           | / / /   | 23d. LOCATION (City or Town     | n) (Cou        | onty) (State)        |  |  |
| 1             | MUKING JU   |                                      | LLE CEMETERY  | DX1061501                       | ILLE           | LAELA.               |  |  |
| 1             | 24. FUNERAL DIRECTOR Lewis W. M.  | Knatt -ADDRESS                       | 2Sa. RECO BY  |                                 | ISTRAR'S SIGNA | _                    |  |  |
| 1             |   | L Va ( DODALL.                       | / Day Louis OCT   | 2 5 40dc 00                     | 7/1            | 11 1.0               |  |  |

TO FUNERAL DIRECTOR: After this certificate has been signed by the ottending physician and completely filled in by the funeral director, page 3 should be detoched for use os the burial-transit permit then pleose remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removed, and in any event, within 72 hours ofter death. Poge 4 moy be retained by the hospital or ottending physician. VR A15 (4) 20 M 1/66

IO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours ofter death.

The state of the s TO TO THE STATE OF THE STATE OF